SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Filing at a Glance

Company: CIGNA Health and Life Insurance Company

Product Name: Group Medical Benefits	SERFF Tr Num: CCGH-126653734	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 46221
Sub-TOI: H16G.002C Large Group Only - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Melissa Pine	Disposition Date: 09/14/2010
	Date Submitted: 07/16/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Filed simultaneously in Connecticut, our state of domicile.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer, Association, Trust
Filing Status Changed: 09/14/2010	Explanation for Other Group Market Type:
	State Status Changed: 09/14/2010
Deemer Date:	Created By: Dewey Post
Submitted By: Melissa Pine	Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

Filing Description:

We are submitting for your review and approval new Medical, Vision and Pharmacy Master Policy and Master Certificate form series for use with CIGNA Life and Health Insurance Company.

The proposed Master Policy documents (the HP form series) and Master Certificate documents (the HC form series) are presented to you as an insert page matrix of forms. The insert page matrix allows us the flexibility to create Policy and

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Certificate documents for our customers through a streamlined, automated document production system. Roughly 75% of the language in any of the Policy and Certificate documents we produce for the various products we market is the same, regardless of the product being sold. For example, Eligibility and Termination provisions are common across all of our Medical products – that is, there are not different Eligibility standards for a PPO plan versus a Comprehensive Medical Plan. The insert page matrix approach allows us to maintain one version of Eligibility text for all group health policies in a state, rather than having to maintain multiple copies of the same Eligibility text for many different product types.

The form matrix included in this filing supports the following CIGNA Health and Life Insurance Company products:
* Network Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Network Open Access Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Point of Service Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Point of Service Open Access Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Preferred Provider Organization Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Open Access Plus Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Exclusive Provider Organization Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Open Access Plus In-Network Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Comprehensive Medical Benefits (with or without Pharmacy and/or Vision benefits)
* Pharmacy Benefits (sold on standalone basis)
* Vision (sold on a standalone basis)

The deductible and out-of-pocket maximum ranges expressed in the Schedules of Insurance include in this filing are also intended to meet federal requirements for annual deductible and out-of-pocket maximums for High Deductible Health Plans sold in connection with Health Savings Accounts.

Additionally, matrix pages have been included in this submission which will allow a standard insurance certificate to be turned into an Individual Conversion Policy. The matrix page approach, especially in this scenario, will allow us to update our documents – of all varieties – for compliance consistently and in a timely fashion.

These forms do not replace any forms currently on file with your department.

Company and Contact

Filing Contact Information

Melissa Pine, Compliance Sr. Associate
900 Cottage Grove Road
B6LPA
Hartford, CT 06152

Melissa.Pine@CIGNA.com
860-226-7574 [Phone]
860-226-5400 [FAX]

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Filing Company Information

CIGNA Health and Life Insurance Company	CoCode: 67369	State of Domicile: Connecticut
900 Cottage Grove Road	Group Code: 901	Company Type: LAH
Hartford, CT 06152	Group Name:	State ID Number:
(860) 226-6000 ext. [Phone]	FEIN Number: 59-1031071	

Filing Fees

Fee Required?	Yes
Fee Amount:	$6,750.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CIGNA Health and Life Insurance Company	$6,750.00	07/16/2010	38085803

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/14/2010	09/14/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/01/2010	09/01/2010	Melissa Pine	09/10/2010	09/10/2010
Pending Industry Response	Rosalind Minor	08/04/2010	08/04/2010	Melissa Pine	08/25/2010	08/25/2010

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/14/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	CHLIC Forms Listing	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Policy Application	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Policy Amendment – General Use	Approved-Closed	Yes
Form	Policy Amendment/Rider – Minimum Premium	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Certification	Approved-Closed	Yes
Form	Introduction (for use with Preferred Provider or Exclusive Provider Plans)	Approved-Closed	Yes
Form	Case Management	Approved-Closed	Yes
Form	Additional Programs	Approved-Closed	Yes
Form	Appeals Notice	Approved-Closed	Yes
Form	Emergency and Urgent Care Notice	Approved-Closed	Yes
Form	Important Notices	Approved-Closed	Yes
Form	How to File Your Claim	Approved-Closed	Yes
Form *(revised)*	Eligibility – Effective Date	Approved-Closed	Yes
Form	Eligibility – Effective Date	Replaced	Yes
Form	Eligibility – Effective Date (Supplemental Medical Benefits)	Approved-Closed	Yes
Form	Important Information About Your Medical Benefits (for use with Open Access Plus or Open Access Plus in-Network plans)	Approved-Closed	Yes
Form	Important Information About Your Medical Benefits (for use with Open Access Plus or Open Access Plus in-Network plans)	Approved-Closed	Yes
Form	Schedule of Insurance (for use with Point of Service, Point of Service Open Access, Preferred Provider or Open Access Plus plans	Approved-Closed	Yes
Form	Schedule of Insurance (for use with Network, Network Open Access,	Approved-Closed	Yes

	Exclusive Provider, Open Access Plus In-Network or Comprehensive Medical plans)		
Form	Certification Requirements (for use with Point of Service, Point of Service Open Access, Preferred Provider, Open Access Plus or Comprehensive Medical plans)	Approved-Closed	Yes
Form	Prior Authorization	Approved-Closed	Yes
Form	Covered Expenses	Approved-Closed	Yes
Form	Covered Expenses (continued) (coverage of morbid obesity)	Approved-Closed	Yes
Form	Covered Expenses (continued) (coverage of orthognathic surgery)	Approved-Closed	Yes
Form	Covered Expenses (continued) (coverage of cardiac rehabilitation)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Home Health Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Hospice Care Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Mental Health and Substance Abuse Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Durable Medical Equipment)	Approved-Closed	Yes
Form	Covered Expenses (continued) (External Prosthetic Appliances and Devices)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Infertility Services – Option I)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Infertility Services – Option II)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Short-Term Rehabilitative Therapy and Chiropractic Care Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Short-Term Rehabilitative Therapy/Chiropractic Care Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Breast Reconstruction and Breast Prostheses/Reconstructive Surgery)	Approved-Closed	Yes

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Form	Covered Expenses (continued) (Transplant Services)	Approved-Closed	Yes
Form	Covered Expenses (continued) (Prescription Drug Benefits – covered under Medical)	Approved-Closed	Yes
Form	Supplemental Medical Benefits (Covered Expenses)	Approved-Closed	Yes
Form *(revised)*	Medical Conversion Privilege	Approved-Closed	Yes
Form	Medical Conversion Privilege	Replaced	Yes
Form	Prescription Drug Benefits – The Schedule	Approved-Closed	Yes
Form	Prescription Drug Benefits – Covered Expenses	Approved-Closed	Yes
Form	Prescription Drug Benefits – Limitations	Approved-Closed	Yes
Form	Prescription Drug Benefits – Your Payments	Approved-Closed	Yes
Form	Prescription Drug Benefits – Exclusions	Approved-Closed	Yes
Form	Prescription Drug Benefits – Reimbursement-Filing a Claim	Approved-Closed	Yes
Form	Vision – Covered Expenses	Approved-Closed	Yes
Form	Vision – Expenses Not Covered	Approved-Closed	Yes
Form	Vision – Covered Expenses & Exclusions	Approved-Closed	Yes
Form	Vision – Covered Expenses, Limitations & Expenses Not Covered	Approved-Closed	Yes
Form	Vision – Schedule of Vision Benefits	Approved-Closed	Yes
Form	Exclusions, Expenses Not Covered and General Limitations	Approved-Closed	Yes
Form	Exclusions, Expenses Not Covered and General Limitations – Pre-existing Condition Limitation	Approved-Closed	Yes
Form	Supplemental Medical Benefits – General Limitations	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Coordination of Benefits – Non-Duplication of Benefits	Approved-Closed	Yes
Form	Expenses for Which a Third Party May Be Liable	Approved-Closed	Yes
Form	Payment of Benefits		

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

		Approved-Closed	Yes
Form	Termination of Insurance	Approved-Closed	Yes
Form	Termination of Supplemental Medical Benefits	Approved-Closed	Yes
Form	Termination of Insurance	Approved-Closed	Yes
Form	Medical Benefits Extension	Approved-Closed	Yes
Form	When You Have a Complaint or Appeal	Approved-Closed	Yes
Form	Active Service	Approved-Closed	Yes
Form	Bed And Board	Approved-Closed	Yes
Form	Charges	Approved-Closed	Yes
Form	Chiropractic Care	Approved-Closed	Yes
Form	Custodial Services	Approved-Closed	Yes
Form	Custodial Services	Approved-Closed	Yes
Form *(revised)*	Dependent	Approved-Closed	Yes
Form	Dependent	Replaced	Yes
Form	Domestic Partner	Approved-Closed	Yes
Form	Emergency Services/Emergency Medical	Approved-Closed	Yes
Form	Employee	Approved-Closed	Yes
Form	Employer	Approved-Closed	Yes
Form	Employer Trustee	Approved-Closed	Yes
Form	Expense Incurred	Approved-Closed	Yes
Form	Free-Standing Surgical Facility	Approved-Closed	Yes
Form	Hospice Care Program	Approved-Closed	Yes
Form	Hospice Care Services	Approved-Closed	Yes
Form	Hospice Facility	Approved-Closed	Yes
Form	Hospital	Approved-Closed	Yes
Form	Hospital Confinement Or Confined In A Hospital	Approved-Closed	Yes
Form	Injury	Approved-Closed	Yes
Form	In-Network/Out-of-Network	Approved-Closed	Yes
Form	Maintenance Treatment	Approved-Closed	Yes
Form	Maintenance Medication	Approved-Closed	Yes
Form	Maximum Reimbursable Charge	Approved-Closed	Yes
Form	Maximum Reimbursable Charge	Approved-Closed	Yes
Form	Medicaid	Approved-Closed	Yes
Form	Medicare	Approved-Closed	Yes

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Form	Medically Necessary	Approved-Closed	Yes
Form	Necessary Services or Supplies	Approved-Closed	Yes
Form	Nurse	Approved-Closed	Yes
Form	Ophthalmologist	Approved-Closed	Yes
Form	Optician	Approved-Closed	Yes
Form	Optometrist	Approved-Closed	Yes
Form	Orphan Designation	Approved-Closed	Yes
Form	Other Health Care Facility	Approved-Closed	Yes
Form	Participating Pharmacy	Approved-Closed	Yes
Form	Participating Provider	Approved-Closed	Yes
Form	Participation Date	Approved-Closed	Yes
Form	Pharmacy	Approved-Closed	Yes
Form	Pharmacy and Therapeutics Committee	Approved-Closed	Yes
Form	Physician	Approved-Closed	Yes
Form	Prescription Drug	Approved-Closed	Yes
Form	Prescription Drug List	Approved-Closed	Yes
Form	Prescription Order	Approved-Closed	Yes
Form	Preventive Medication	Approved-Closed	Yes
Form	Preventive Treatment	Approved-Closed	Yes
Form	Primary Care Physician	Approved-Closed	Yes
Form	Priority Review	Approved-Closed	Yes
Form	Psychologist	Approved-Closed	Yes
Form	Psychologist	Approved-Closed	Yes
Form	Related Supplies	Approved-Closed	Yes
Form	Review Organization	Approved-Closed	Yes
Form	Sickness	Approved-Closed	Yes
Form	Skilled Nursing Facility	Approved-Closed	Yes
Form	Specialist	Approved-Closed	Yes
Form	Specialty Medication	Approved-Closed	Yes
Form	Terminal Illness	Approved-Closed	Yes
Form	Urgent care	Approved-Closed	Yes
Form	Vision Provider	Approved-Closed	Yes
Form	Minimum Premium Rider	Approved-Closed	Yes
Form	Certificate Rider – General Use	Approved-Closed	Yes
Form *(revised)*	Eligibility Effective Date for Conversion Policy	Approved-Closed	Yes

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Form	Eligibility Effective Date for Conversion Policy	Approved-Closed	Yes
Form	Subrogation for Conversion Policy	Approved-Closed	Yes
Form	Continuation for Surviving Spouse/Dep for Conversion Policy	Approved-Closed	Yes
Form *(revised)*	Termination for Conversion Policy	Approved-Closed	Yes
Form	Termination for Conversion Policy	Replaced	Yes
Form	Termination for Conversion Policy	Replaced	Yes
Form	Group Health Plan for Conversion Policy	Approved-Closed	Yes
Form	Policy Year for Conversion Policy	Approved-Closed	Yes
Form	Policy for Conversion Policy	Approved-Closed	Yes
Form	Application for Conversion Policy	Approved-Closed	Yes
Form	Overinsured for Conversion Policy	Approved-Closed	Yes
Form	Previous Plan for Conversion Policy	Approved-Closed	Yes
Form	Certification for Conversion Policy	Approved-Closed	Yes
Form	Premiums/Miscellaneous and General Provisions for Conversion Policy	Approved-Closed	Yes

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/01/2010
Submitted Date	09/01/2010
Respond By Date	

Dear Melissa Pine,

This will acknowledge receipt of the captioned filing.

Objection 1

- Termination for Conversion Policy, HC-TRM10 (Form)

Comment:

I still have a problem with item #4 under Termination of Insurance and item #5 under Dependents. Shouldn't the statement read...."The end of the period for which you have failed to pay the required premium....?

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/10/2010
Submitted Date	09/10/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: We have revised the text on HC-TRM10 to clairfy our position. I have included both a redline and final version of the revised form.

Related Objection 1

Applies To:

- Termination for Conversion Policy, HC-TRM10 (Form)

Comment:

I still have a problem with item #4 under Termination of Insurance and item #5 under Dependents. Shouldn't the statement read...."The end of the period for which you have failed to pay the required premium....?

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Termination for Conversion Policy	HC-TRM10		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.900	HC-TRM10 Redline 9-1 REVISION

				V1.pdf,HC -TRM10 9-1 REVISION V1.pdf
Previous Version				
Termination for Conversion Policy	*HC-TRM10*	*Certificate Amendment, Initial Insert Page, Endorsement or Rider*	*46.900*	HC-TRM10 REVISION V1.pdf,HC -TRM10 REDLINE REVISION V1.pdf
Termination for Conversion Policy	*HC-TRM10*	*Certificate Amendment, Initial Insert Page, Endorsement or Rider*	*46.900*	HC-TRM10.pdf

No Rate/Rule Schedule items changed.

Please let us know if you have further questions. Have a great weekend.

Sincerely,
Melissa Pine

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/04/2010
Submitted Date	08/04/2010
Respond By Date	09/06/2010

Dear Melissa Pine,

This will acknowledge receipt of the captioned filing.

Objection 1

- Eligibility – Effective Date, HC-ELG1 (Form)

Comment:

Coverage for newborn infants must be for at least 90 days. Please refer to ACA 23-79-129.

Objection 2

- Medical Conversion Privilege, HC-CNV1 (Form)

Comment:

Your Conversion Priviledge does not comply with our Conversion Law, ACA 23-86-115. Our law does not contain a limitation that the insured must be covered for 3 months.

Objection 3

- Dependent, HC-DFS46 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 4

- Eligibility Effective Date for Conversion Policy, HC-ELG7 (Form)

Comment:

Our Conversion Law, ACA 23-86-115 does not allow a 3 month limitation as outlined under item #2.

Objection 5

- Termination for Conversion Policy, HC-TRM10 (Form)

Comment:

The form indicates that the insurance will cease on the earliest date outlined on the form: Item #4 indicates at the end of

the 3 month period for which you have paid the required premium. Please explain why a Conversion policy will terminate when an insured is paying the premiums.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/25/2010
Submitted Date	08/25/2010

Dear Rosalind Minor,

Comments:
Thank you for your response on August 4, 2010. I have responded to each of your objections individaully below.

Response 1

Comments: HC-ELG1 has been revised to reflect coverage for newborn infants for at least 90 days. Redline and Final versions have been submitted for your reference.

Related Objection 1

Applies To:

- Eligibility – Effective Date, HC-ELG1 (Form)

Comment:

Coverage for newborn infants must be for at least 90 days. Please refer to ACA 23-79-129.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Eligibility – Effective Date	HC-ELG1		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.900	HC-ELG1 REVISION V2.pdf,HC-ELG1REDLINE REVISION

V2.pdf

Previous Version

Eligibility – Effective Date	*HC-ELG1*	*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*	*46.900*	HC-ELG1.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: HC-CNV1 has been revised to comply with AR Conversion law. We have removed the limitation that indicated that the insured must be covered for 3 months. Redline and Final versions have been submitted for your reference.

Related Objection 1

Applies To:

- Medical Conversion Privilege, HC-CNV1 (Form)

Comment:

Your Conversion Priviledge does not comply with our Conversion Law, ACA 23-86-115. Our law does not contain a limitation that the insured must be covered for 3 months.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medical Conversion Privilege	HC-CNV1		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.900	HC-CNV1 REVISION V1.pdf,HC-CNV1 REDLINE REVISION V1.pdf

Previous Version

Medical Conversion Privilege	*HC-CNV1*	*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*	*46.900*	HC-CNV1.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: HC-DFS46 has been revised to comply with ACA 23-86-108(4) and Bulletin 14-81. Redline and final versions have been submitted for your review.

Related Objection 1

Applies To:

- Dependent, HC-DFS46 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dependent	HC-DFS46		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.900	HC-DFS46 REVISION V1.pdf,HC-DFS46 REDLINE REVISION V1.pdf

Previous Version

Dependent	*HC-DFS46*	*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*	*46.900*	HC-DFS46.pdf

No Rate/Rule Schedule items changed.

Response 4

Comments: HC-ELG7 has been revised. We have removed the 3 month limitation. Redline and Final versions have been submitted for your reference.

Related Objection 1

Applies To:

- Eligibility Effective Date for Conversion Policy, HC-ELG7 (Form)

Comment:

Our Conversion Law, ACA 23-86-115 does not allow a 3 month limitation as outlined under item #2.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Eligibility Effective Date for Conversion Policy	HC-ELG7		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.900	HC-ELG7 REVISION V1.pdf,HC-ELG7 REDLINE REVISION V1.pdf
Previous Version							
Eligibility Effective Date for Conversion Policy	*HC-ELG7*		*Certificate Amendment, Insert Page, Endorsement*	*Initial*		*46.900*	HC-ELG7.pdf

or Rider

No Rate/Rule Schedule items changed.

Response 5

Comments: HC-CNV1 has been revised and no longer references the 3 month period. Redline and final versions have been submitted for your reference.

Related Objection 1

Applies To:

- Termination for Conversion Policy, HC-TRM10 (Form)

Comment:

The form indicates that the insurance will cease on the earliest date outlined on the form: Item #4 indicates at the end of the 3 month period for which you have paid the required premium. Please explain why a Conversion policy will terminate when an insured is paying the premiums.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Termination for Conversion Policy	*HC-TRM10*		*Certificate Amendment, Insert Page, Endorsement or Rider*	*Initial*		*46.900*	HC-TRM10 REVISION V1.pdf,HC-TRM10 REDLINE REVISION V1.pdf
Previous Version							
Termination for Conversion Policy	*HC-TRM10*		*Certificate Amendment, Insert Page, Endorsement*	*Initial*		*46.900*	HC-TRM10.pd

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

or Rider f

No Rate/Rule Schedule items changed.

Thank you very much for the opportunity to revise this submission. Please let me know if you have further questions.

Sincerely,
Melissa Pine

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/14/2010	HP-APP-1	Application/Enrollment Form	Policy Application	Initial		46.900	HP-APP-1 cat # 831494 (Generic).pdf
Approved-Closed 09/14/2010	HP-POL	Policy/Contract/Fraternal Certificate	Policy	Initial		46.900	HP-POL3.pdf
Approved-Closed 09/14/2010	HP-AMD1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Amendment – General Use	Initial		46.900	HP-AMD1 _General Amendment for Policy Revisions_.pdf
Approved-Closed 09/14/2010	HP-AMD2	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Amendment/Rider – Minimum Premium	Initial		46.900	HP-AMD2 _Minimum Premium_.pdf
Approved-Closed 09/14/2010	HC-TOC1	Certificate Amendment, Insert Page, Endorsement or Rider	Table of Contents	Initial		46.900	HC-TOC1.pdf

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*		
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*		
Company Tracking Number:					
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*		
Product Name:	*Group Medical Benefits*				
Project Name/Number:	*/*				

Approved-Closed 09/14/2010	HC-CER1	Certificate Amendment, Insert Page, Endorsement or Rider	Certification	Initial		46.900	HC-CER1.pdf
Approved-Closed 09/14/2010	HC-SPP1	Certificate Amendment, Insert Page, Endorsement or Rider	Introduction (for use with Preferred Provider or Exclusive Provider Plans)	Initial		46.900	HC-SPP1 (PPO-EPO Introduction not for Comp Medical).pdf
Approved-Closed 09/14/2010	HC-SPP2	Certificate Amendment, Insert Page, Endorsement or Rider	Case Management	Initial		46.900	HC-SPP2 _Case Management _.pdf
Approved-Closed 09/14/2010	HC-SPP3	Certificate Amendment, Insert Page, Endorsement or Rider	Additional Programs	Initial		46.900	HC-SPP3 _Additional Programs_.pdf
Approved-Closed 09/14/2010	HC-SPP4	Certificate Amendment, Insert Page, Endorsement or Rider	Appeals Notice	Initial		46.900	HC-SPP4 _Appeals Notice_.pdf
Approved-Closed 09/14/2010	HC-SPP5	Certificate Amendment, Insert Page, Endorsement or Rider	Emergency and Urgent Care Notice	Initial		46.900	HC-SPP5 _Emergency and Urgent Care Notice_.pdf
Approved-Closed	HC-IMP24	Certificate Amendmen	Important Notices	Initial		46.900	HC-IMP24.pdf

09/14/2010		t, Insert Page, Endorsement or Rider					
Approved-Closed 09/14/2010	HC-CLM1	Certificate Amendment, Insert Page, Endorsement or Rider	How to File Your Claim	Initial		46.900	HC-CLM1.pdf
Approved-Closed 09/14/2010	HC-ELG1	Certificate Amendment, Insert Page, Endorsement or Rider	Eligibility – Effective Date	Initial		46.900	HC-ELG1 REVISION V2.pdf HC-ELG1REDLINE REVISION V2.pdf
Approved-Closed 09/14/2010	HC-ELG2	Certificate Amendment, Insert Page, Endorsement or Rider	Eligibility – Effective Date (Supplemental Medical Benefits)	Initial		46.900	HC-ELG2 _MERP_.pdf
Approved-Closed 09/14/2010	HC-IMP1	Certificate Amendment, Insert Page, Endorsement or Rider	Important Information About Your Medical Benefits (for use with Open Access Plus or Open Access Plus in-Network plans)	Initial		46.900	HC-IMP1.pdf
Approved-Closed 09/14/2010	HC-IMP3	Certificate Amendment, Insert Page, Endorsement or Rider	Important Information About Your Medical Benefits (for use with Open Access Plus or Open Access Plus in-Network plans)	Initial		46.900	HC-IMP3.pdf
Approved-Closed 09/14/2010	HC-SOC135	Certificate Amendment, Insert	Schedule of Insurance (for use with Point of Service,	Initial		46.900	HC-SOC135 PPACA (IN and OON

		Page, Endorsement or Rider	Point of Service Open Access, Preferred Provider or Open Access Plus plans			Schedule).pdf
Approved-Closed 09/14/2010	HC-SOC136	Certificate Amendment, Insert Page, Endorsement or Rider	Schedule of Insurance (for use with Network, Network Open Access, Exclusive Provider, Open Access Plus In-Network or Comprehensive Medical plans)	Initial	46.900	HC-SOC136 PPACA (IN and COMP Schedule).pdf
Approved-Closed 09/14/2010	HC-PAC1	Certificate Amendment, Insert Page, Endorsement or Rider	Certification Requirements (for use with Point of Service, Point of Service Open Access, Preferred Provider, Open Access Plus or Comprehensive Medical plans)	Initial	46.900	HC-PAC1.pdf
Approved-Closed 09/14/2010	HC-PRA1	Certificate Amendment, Insert Page, Endorsement or Rider	Prior Authorization	Initial	46.900	HC-PRA1.pdf
Approved-Closed 09/14/2010	HC-COV145	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses	Initial	46.900	HC-COV145.pdf
Approved-	HC-COV2	Certificate	Covered Expenses	Initial	46.900	HC-COV2.pdf

Closed 09/14/2010		Amendment, Insert Page, Endorsement or Rider	(continued) (coverage of morbid obesity)				
Approved-Closed 09/14/2010	HC-COV3	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (coverage of orthognathic surgery)	Initial		46.900	HC-COV3.pdf
Approved-Closed 09/14/2010	HC-COV4	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (coverage of cardiac rehabilitation)	Initial		46.900	HC-COV4.pdf
Approved-Closed 09/14/2010	HC-COV5	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Home Health Services)	Initial		46.900	HC-COV5.pdf
Approved-Closed 09/14/2010	HC-COV6	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Hospice Care Services)	Initial		46.900	HC-COV6.pdf
Approved-Closed 09/14/2010	HC-COV7	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Mental Health and Substance Abuse Services)	Initial		46.900	HC-COV7.pdf
Approved-Closed 09/14/2010	HC-COV8	Certificate Amendment, Insert	Covered Expenses (continued) (Durable Medical Equipment)	Initial		46.900	HC-COV8.pdf

		Page, Endorsement or Rider					
Approved-Closed 09/14/2010	HC-COV9	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (External Prosthetic Appliances and Devices)	Initial		46.900	HC-COV9.pdf
Approved-Closed 09/14/2010	HC-COV10	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Infertility Services – Option I)	Initial		46.900	HC-COV10.pdf
Approved-Closed 09/14/2010	HC-COV11	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Infertility Services – Option II)	Initial		46.900	HC-COV11.pdf
Approved-Closed 09/14/2010	HC-COV12	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Short-Term Rehabilitative Therapy and Chiropractic Care Services)	Initial		46.900	HC-COV12.pdf
Approved-Closed 09/14/2010	HC-COV13	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Short-Term Rehabilitative Therapy/Chiropractic Care Services)	Initial		46.900	HC-COV13.pdf
Approved-Closed 09/14/2010	HC-COV14	Certificate Amendment, Insert Page, Endorsement	Covered Expenses (continued) (Breast Reconstruction and Breast Prostheses/Reconstr	Initial		46.900	HC-COV14.pdf

		nt or Rider	uctive Surgery)				
Approved-Closed 09/14/2010	HC-COV15	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Transplant Services)	Initial		46.900	HC-COV15.pdf
Approved-Closed 09/14/2010	HC-COV16	Certificate Amendment, Insert Page, Endorsement or Rider	Covered Expenses (continued) (Prescription Drug Benefits – covered under Medical)	Initial		46.900	HC-COV16.pdf
Approved-Closed 09/14/2010	HC-MRP1	Certificate Amendment, Insert Page, Endorsement or Rider	Supplemental Medical Benefits (Covered Expenses)	Initial		46.900	HC-MRP1.pdf
Approved-Closed 09/14/2010	HC-CNV1	Certificate Amendment, Insert Page, Endorsement or Rider	Medical Conversion Privilege	Initial		46.900	HC-CNV1 REVISION V1.pdf HC-CNV1 REDLINE REVISION V1.pdf
Approved-Closed 09/14/2010	HC-SOC116	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – The Schedule	Initial		46.900	HC-SOC116.pdf
Approved-Closed 09/14/2010	HC-PHR1	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – Covered Expenses	Initial		46.900	HC-PHR1.pdf

SERFF Tracking Number:	*CCGH-126653734*		*State:*	*Arkansas*		
Filing Company:	*CIGNA Health and Life Insurance Company*		*State Tracking Number:*	*46221*		
Company Tracking Number:						
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002C Large Group Only - Other*		
Product Name:	*Group Medical Benefits*					
Project Name/Number:	*/*					
Approved-Closed 09/14/2010	HC-PHR2	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – Limitations	Initial	46.900	HC-PHR2.pdf
Approved-Closed 09/14/2010	HC-PHR3	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – Your Payments	Initial	46.900	HC-PHR3.pdf
Approved-Closed 09/14/2010	HC-PHR4	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – Exclusions	Initial	46.900	HC-PHR4.pdf
Approved-Closed 09/14/2010	HC-PHR5	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Benefits – Reimbursement-Filing a Claim	Initial	46.900	HC-PHR5.pdf
Approved-Closed 09/14/2010	HC-VIS1	Certificate Amendment, Insert Page, Endorsement or Rider	Vision – Covered Expenses	Initial	46.900	HC-VIS1.pdf
Approved-Closed 09/14/2010	HC-VIS2	Certificate Amendment, Insert Page, Endorsement or Rider	Vision – Expenses Not Covered	Initial	46.900	HC-VIS2.pdf
Approved-Closed	HC-VIS3	Certificate Amendment	Vision – Covered Expenses &	Initial	46.900	HC-VIS3.pdf

09/14/2010		t, Insert Page, Endorsement or Rider	Exclusions				
Approved-Closed 09/14/2010	HC-VIS4	Certificate Amendment, Insert Page, Endorsement or Rider	Vision – Covered Expenses, Limitations & Expenses Not Covered	Initial		46.900	HC-VIS4.pdf
Approved-Closed 09/14/2010	HC-VIS5	Certificate Amendment, Insert Page, Endorsement or Rider	Vision – Schedule of Vision Benefits	Initial		46.900	HC-VIS5.pdf
Approved-Closed 09/14/2010	HC-EXC1	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions, Expenses Not Covered and General Limitations	Initial		46.900	HC-EXC1.pdf
Approved-Closed 09/14/2010	HC-EXC3	Certificate Amendment, Insert Page, Endorsement or Rider	Exclusions, Expenses Not Covered and General Limitations – Pre-existing Condition Limitation	Initial		46.900	HC-EXC3.pdf
Approved-Closed 09/14/2010	HC-MRP2	Certificate Amendment, Insert Page, Endorsement or Rider	Supplemental Medical Benefits – General Limitations	Initial		46.900	HC-MRP2.pdf
Approved-Closed 09/14/2010	HC-COB1	Certificate Amendment, Insert Page,	Coordination of Benefits	Initial		46.900	HC-COB1 _File in all states EXCEPT AZ,

		Endorsement or Rider					CT, ID, KY, MD, MA,….pdf
Approved-Closed 09/14/2010	HC-COB3	Certificate Amendment, Insert Page, Endorsement or Rider	Coordination of Benefits – Non-Duplication of Benefits	Initial		46.900	HC-COB3_Non-D File in all states EXCEPT AZ, CT, ID, KY, M….pdf
Approved-Closed 09/14/2010	HC-SUB2	Certificate Amendment, Insert Page, Endorsement or Rider	Expenses for Which a Third Party May Be Liable	Initial		46.900	HC-SUB2.pdf
Approved-Closed 09/14/2010	HC-POB1	Certificate Amendment, Insert Page, Endorsement or Rider	Payment of Benefits	Initial		46.900	HC-POB1.pdf
Approved-Closed 09/14/2010	HC-TRM1	Certificate Amendment, Insert Page, Endorsement or Rider	Termination of Insurance	Initial		46.900	HC-TRM1.pdf
Approved-Closed 09/14/2010	HC-TRM2	Certificate Amendment, Insert Page, Endorsement or Rider	Termination of Supplemental Medical Benefits	Initial		46.900	HC-TRM2_MERP_.pdf
Approved-Closed 09/14/2010	HC-TRM58	Certificate Amendment, Insert Page, Endorseme	Termination of Insurance	Initial		46.900	HC-TRM58.pdf

		nt or Rider				
Approved-Closed 09/14/2010	HC-BEX20	Certificate Amendment, Insert Page, Endorsement or Rider	Medical Benefits Extension	Initial	46.900	HC-BEX20.pdf
Approved-Closed 09/14/2010	HC-APL22	Certificate Amendment, Insert Page, Endorsement or Rider	When You Have a Complaint or Appeal	Initial	46.900	HC-APL22.pdf
Approved-Closed 09/14/2010	HC-DFS1	Certificate Amendment, Insert Page, Endorsement or Rider	Active Service	Initial	46.900	HC-DFS1.pdf
Approved-Closed 09/14/2010	HC-DFS2	Certificate Amendment, Insert Page, Endorsement or Rider	Bed And Board	Initial	46.900	HC-DFS2.pdf
Approved-Closed 09/14/2010	HC-DFS3	Certificate Amendment, Insert Page, Endorsement or Rider	Charges	Initial	46.900	HC-DFS3.pdf
Approved-Closed 09/14/2010	HC-DFS55	Certificate Amendment, Insert Page, Endorsement or Rider	Chiropractic Care	Initial	46.900	HC-DFS55.pdf
Approved-	HC-DFS4	Certificate	Custodial Services	Initial	46.900	HC-DFS4.pdf

Closed 09/14/2010		Amendment, Insert Page, Endorsement or Rider					
Approved-Closed 09/14/2010	HC-DFS5	Certificate Amendment, Insert Page, Endorsement or Rider	Custodial Services	Initial		46.900	HC-DFS5.pdf
Approved-Closed 09/14/2010	HC-DFS46	Certificate Amendment, Insert Page, Endorsement or Rider	Dependent	Initial		46.900	HC-DFS46 REVISION V1.pdf HC-DFS46 REDLINE REVISION V1.pdf
Approved-Closed 09/14/2010	HC-DFS47	Certificate Amendment, Insert Page, Endorsement or Rider	Domestic Partner	Initial		46.900	HC-DFS47.pdf
Approved-Closed 09/14/2010	HC-DFS6	Certificate Amendment, Insert Page, Endorsement or Rider	Emergency Services/Emergency Medical	Initial		46.900	HC-DFS6.pdf
Approved-Closed 09/14/2010	HC-DFS7	Certificate Amendment, Insert Page, Endorsement or Rider	Employee	Initial		46.900	HC-DFS7.pdf
Approved-Closed	HC-DFS8	Certificate Amendment	Employer	Initial		46.900	HC-DFS8.pdf

09/14/2010		t, Insert Page, Endorsement or Rider					
Approved-Closed 09/14/2010	HC-DFS9	Certificate Amendment, Insert Page, Endorsement or Rider	Employer Trustee	Initial		46.900	HC-DFS9.pdf
Approved-Closed 09/14/2010	HC-DFS10	Certificate Amendment, Insert Page, Endorsement or Rider	Expense Incurred	Initial		46.900	HC-DFS10.pdf
Approved-Closed 09/14/2010	HC-DFS11	Certificate Amendment, Insert Page, Endorsement or Rider	Free-Standing Surgical Facility	Initial		46.900	HC-DFS11.pdf
Approved-Closed 09/14/2010	HC-DFS51	Certificate Amendment, Insert Page, Endorsement or Rider	Hospice Care Program	Initial		46.900	HC-DFS51.pdf
Approved-Closed 09/14/2010	HC-DFS52	Certificate Amendment, Insert Page, Endorsement or Rider	Hospice Care Services	Initial		46.900	HC-DFS52.pdf
Approved-Closed 09/14/2010	HC-DFS53	Certificate Amendment, Insert Page,	Hospice Facility	Initial		46.900	HC-DFS53.pdf

		Endorsement or Rider				
Approved-Closed 09/14/2010	HC-DFS48	Certificate Amendment, Insert Page, Endorsement or Rider	Hospital	Initial	46.900	HC-DFS48.pdf
Approved-Closed 09/14/2010	HC-DFS49	Certificate Amendment, Insert Page, Endorsement or Rider	Hospital Confinement Or Confined In A Hospital	Initial	46.900	HC-DFS49.pdf
Approved-Closed 09/14/2010	HC-DFS12	Certificate Amendment, Insert Page, Endorsement or Rider	Injury	Initial	46.900	HC-DFS12.pdf
Approved-Closed 09/14/2010	HC-DFS37	Certificate Amendment, Insert Page, Endorsement or Rider	In-Network/Out-of-Network	Initial	46.900	HC-DFS37.pdf
Approved-Closed 09/14/2010	HC-DFS56	Certificate Amendment, Insert Page, Endorsement or Rider	Maintenance Treatment	Initial	46.900	HC-DFS56.pdf
Approved-Closed 09/14/2010	HC-DFS58	Certificate Amendment, Insert Page, Endorsement or Rider	Maintenance Medication	Initial	46.900	HC-DFS58.pdf

SERFF Tracking Number:	*CCGH-126653734*		*State:*	*Arkansas*			
Filing Company:	*CIGNA Health and Life Insurance Company*		*State Tracking Number:*	*46221*			
Company Tracking Number:							
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002C Large Group Only - Other*			
Product Name:	*Group Medical Benefits*						
Project Name/Number:	*/*						
Approved-Closed 09/14/2010	HC-DFS13	Certificate Amendment, Insert Page, Endorsement or Rider	Maximum Reimbursable Charge	Initial		46.900	HC-DFS13.pdf
Approved-Closed 09/14/2010	HC-DFS14	Certificate Amendment, Insert Page, Endorsement or Rider	Maximum Reimbursable Charge	Initial		46.900	HC-DFS14.pdf
Approved-Closed 09/14/2010	HC-DFS16	Certificate Amendment, Insert Page, Endorsement or Rider	Medicaid	Initial		46.900	HC-DFS16.pdf
Approved-Closed 09/14/2010	HC-DFS17	Certificate Amendment, Insert Page, Endorsement or Rider	Medicare	Initial		46.900	HC-DFS17.pdf
Approved-Closed 09/14/2010	HC-DFS19	Certificate Amendment, Insert Page, Endorsement or Rider	Medically Necessary	Initial		46.900	HC-DFS19.pdf
Approved-Closed 09/14/2010	HC-DFS21	Certificate Amendment, Insert Page, Endorsement or Rider	Necessary Services or Supplies	Initial		46.900	HC-DFS21.pdf
Approved-Closed	HC-DFS22	Certificate Amendmen	Nurse	Initial		46.900	HC-DFS22.pdf

09/14/2010			t, Insert Page, Endorsement or Rider				
Approved-Closed 09/14/2010	HC-DFS70	Certificate Amendment, Insert Page, Endorsement or Rider	Ophthalmologist	Initial		46.900	HC-DFS70.pdf
Approved-Closed 09/14/2010	HC-DFS71	Certificate Amendment, Insert Page, Endorsement or Rider	Optician	Initial		46.900	HC-DFS71.pdf
Approved-Closed 09/14/2010	HC-DFS72	Certificate Amendment, Insert Page, Endorsement or Rider	Optometrist	Initial		46.900	HC-DFS72.pdf
Approved-Closed 09/14/2010	HC-DFS59	Certificate Amendment, Insert Page, Endorsement or Rider	Orphan Designation	Initial		46.900	HC-DFS59.pdf
Approved-Closed 09/14/2010	HC-DFS23	Certificate Amendment, Insert Page, Endorsement or Rider	Other Health Care Facility	Initial		46.900	HC-DFS23.pdf
Approved-Closed 09/14/2010	HC-DFS60	Certificate Amendment, Insert Page,	Participating Pharmacy	Initial		46.900	HC-DFS60.pdf

		Endorsement or Rider					
Approved-Closed 09/14/2010	HC-DFS45	Certificate Amendment, Insert Page, Endorsement or Rider	Participating Provider	Initial		46.900	HC-DFS45.pdf
Approved-Closed 09/14/2010	HC-DFS18	Certificate Amendment, Insert Page, Endorsement or Rider	Participation Date	Initial		46.900	HC-DFS18.pdf
Approved-Closed 09/14/2010	HC-DFS61	Certificate Amendment, Insert Page, Endorsement or Rider	Pharmacy	Initial		46.900	HC-DFS61.pdf
Approved-Closed 09/14/2010	HC-DFS62	Certificate Amendment, Insert Page, Endorsement or Rider	Pharmacy and Therapeutics Committee	Initial		46.900	HC-DFS62.pdf
Approved-Closed 09/14/2010	HC-DFS25	Certificate Amendment, Insert Page, Endorsement or Rider	Physician	Initial		46.900	HC-DFS25.pdf
Approved-Closed 09/14/2010	HC-DFS63	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug	Initial		46.900	HC-DFS63.pdf

SERFF Tracking Number:	*CCGH-126653734*		*State:*	*Arkansas*			
Filing Company:	*CIGNA Health and Life Insurance Company*		*State Tracking Number:*	*46221*			
Company Tracking Number:							
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002C Large Group Only - Other*			
Product Name:	*Group Medical Benefits*						
Project Name/Number:	*/*						
Approved-Closed 09/14/2010	HC-DFS64	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug List	Initial		46.900	HC-DFS64.pdf
Approved-Closed 09/14/2010	HC-DFS65	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Order	Initial		46.900	HC-DFS65.pdf
Approved-Closed 09/14/2010	HC-DFS66	Certificate Amendment, Insert Page, Endorsement or Rider	Preventive Medication	Initial		46.900	HC-DFS66.pdf
Approved-Closed 09/14/2010	HC-DFS57	Certificate Amendment, Insert Page, Endorsement or Rider	Preventive Treatment	Initial		46.900	HC-DFS57.pdf
Approved-Closed 09/14/2010	HC-DFS40	Certificate Amendment, Insert Page, Endorsement or Rider	Primary Care Physician	Initial		46.900	HC-DFS40.pdf
Approved-Closed 09/14/2010	HC-DFS67	Certificate Amendment, Insert Page, Endorsement or Rider	Priority Review	Initial		46.900	HC-DFS67.pdf
Approved-Closed	HC-DFS26	Certificate Amendmen	Psychologist	Initial		46.900	HC-DFS26.pdf

09/14/2010		t, Insert Page, Endorsement or Rider					
Approved-Closed 09/14/2010	HC-DFS27	Certificate Amendment, Insert Page, Endorsement or Rider	Psychologist	Initial		46.900	HC-DFS27.pdf
Approved-Closed 09/14/2010	HC-DFS68	Certificate Amendment, Insert Page, Endorsement or Rider	Related Supplies	Initial		46.900	HC-DFS68.pdf
Approved-Closed 09/14/2010	HC-DFS30	Certificate Amendment, Insert Page, Endorsement or Rider	Review Organization	Initial		46.900	HC-DFS30.pdf
Approved-Closed 09/14/2010	HC-DFS50	Certificate Amendment, Insert Page, Endorsement or Rider	Sickness	Initial		46.900	HC-DFS50.pdf
Approved-Closed 09/14/2010	HC-DFS31	Certificate Amendment, Insert Page, Endorsement or Rider	Skilled Nursing Facility	Initial		46.900	HC-DFS31.pdf
Approved-Closed 09/14/2010	HC-DFS33	Certificate Amendment, Insert Page,	Specialist	Initial		46.900	HC-DFS33.pdf

Approved-Closed 09/14/2010	HC-DFS69	Endorsement or Rider Certificate Amendment, Insert Page, Endorsement or Rider	Specialty Medication	Initial		46.900	HC-DFS69.pdf
Approved-Closed 09/14/2010	HC-DFS54	Certificate Amendment, Insert Page, Endorsement or Rider	Terminal Illness	Initial		46.900	HC-DFS54.pdf
Approved-Closed 09/14/2010	HC-DFS34	Certificate Amendment, Insert Page, Endorsement or Rider	Urgent care	Initial		46.900	HC-DFS34.pdf
Approved-Closed 09/14/2010	HC-DFS73	Certificate Amendment, Insert Page, Endorsement or Rider	Vision Provider	Initial		46.900	HC-DFS73.pdf
Approved-Closed 09/14/2010	HC-MPR1	Certificate	Minimum Premium Rider	Initial		46.900	HC-MPR1.pdf
Approved-Closed 09/14/2010	HC-RDR1	Certificate	Certificate Rider – General Use	Initial		46.900	HC-RDR1.pdf
Approved-Closed 09/14/2010	HC-ELG7	Certificate Amendment, Insert Page, Endorsement or Rider	Eligibility Effective Date for Conversion Policy	Initial		46.900	HC-ELG7 REVISION V1.pdf HC-ELG7 REDLINE REVISION

							V1.pdf
Approved-Closed 09/14/2010	HC-SUB6	Certificate Amendment, Insert Page, Endorsement or Rider	Subrogation for Conversion Policy	Initial		46.900	HC-SUB6.pdf
Approved-Closed 09/14/2010	HC-TRM9	Certificate Amendment, Insert Page, Endorsement or Rider	Continuation for Surviving Spouse/Dep for Conversion Policy	Initial		46.900	HC-TRM9.pdf
Approved-Closed 09/14/2010	HC-TRM10	Certificate Amendment, Insert Page, Endorsement or Rider	Termination for Conversion Policy	Initial		46.900	HC-TRM10 Redline 9-1 REVISION V1.pdf HC-TRM10 9-1 REVISION V1.pdf
Approved-Closed 09/14/2010	HC-DFS91	Certificate Amendment, Insert Page, Endorsement or Rider	Group Health Plan for Conversion Policy	Initial		46.900	HC-DFS91.pdf
Approved-Closed 09/14/2010	HC-DFS92	Certificate Amendment, Insert Page, Endorsement or Rider	Policy Year for Conversion Policy	Initial		46.900	HC-DFS92.pdf
Approved-Closed 09/14/2010	HC-DFS93	Certificate Amendment, Insert Page, Endorsement or Rider	Policy for Conversion Policy	Initial		46.900	HC-DFS93.pdf

SERFF Tracking Number:	*CCGH-126653734*		*State:*	*Arkansas*			
Filing Company:	*CIGNA Health and Life Insurance Company*		*State Tracking Number:*	*46221*			
Company Tracking Number:							
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002C Large Group Only - Other*			
Product Name:	*Group Medical Benefits*						
Project Name/Number:	*/*						
Approved-Closed 09/14/2010	HC-DFS94	Certificate Amendment, Insert Page, Endorsement or Rider	Application for Conversion Policy	Initial		46.900	HC-DFS94.pdf
Approved-Closed 09/14/2010	HC-DFS108	Certificate Amendment, Insert Page, Endorsement or Rider	Overinsured for Conversion Policy	Initial		46.900	HC-DFS108.pdf
Approved-Closed 09/14/2010	HC-DFS109	Certificate Amendment, Insert Page, Endorsement or Rider	Previous Plan for Conversion Policy	Initial		46.900	HC-DFS109.pdf
Approved-Closed 09/14/2010	HP-POL53	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Certification for Conversion Policy	Initial		46.900	HP-POL53.pdf
Approved-Closed 09/14/2010	HP-POL54	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Premiums/Miscellaneous and General Provisions for Conversion Policy	Initial		46.900	HP-POL54.pdf

Application

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CIGNA

1. Name of Applicant	2. Main Address
3. Nature of Business	
4. Classes and Locations of Individuals Eligible	5. Subsidiary and Affiliated Companies Included

6. Total Number of Individuals Eligible	For Individual Benefits	For Dependent Benefits

Have any of the classes of individuals eligible been covered under a group insurance policy or any other form of group plan within the past five years?
☐ Yes ☐ No *If so, please specify the benefits, the underwriting company or organization, and the dates these benefits were terminated.*

7. Group Insurance Applied For: *(Please check all that apply)*

Individual	Dependent		Individual	Dependent	
☐	☐	Life Insurance	☐	☐	Doctors Attendance Benefits
☐	☐	Accidental Death & Dismemberment Insurance	☐	☐	Laboratory and X-ray Examination Benefits
☐	—	Short Term Disability Insurance	☐	☐	Major Medical Benefits
☐	—	Long Term Disability Insurance	☐	☐	Comprehensive Medical Benefits
☐	☐	Hospital Benefits	☐	☐	Dental Benefits
☐	☐	Surgical Benefits	☐	☐	Vision Care Benefits
☐	☐	_____			

8. Effective Date Requested: _____

Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect on the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If this Application is not accepted, no insurance will become effective. Any premium advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

9. THE APPLICANT DECLARES: that he has read the above statement and the answers to the above questions are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that the terms and conditions of the Insurance Company's Proposal for the Group Insurance applied for forms a part of this Application and that this Application will form a part of any policy(s) issued; (3) that only the information on this Application will bind the Insurance Company; and (4) that no waiver or change will bind the Insurance Company unless signed by an Executive Officer of the Insurance Company. Group Insurance will only be provided for persons eligible under the policy(s) issued.

Dated at _____ on _____

Name of Applicant _____

By _____ Title _____

Witness _____ Soliciting Agent if other than Witness _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATEMENT TO BE SIGNED BY APPLICANT UPON PAYMENT OF THE PREMIUM OR ANY PART THEREOF

I HEREBY DECLARE that I have paid to _____ Agent

_____ Dollars for which I hold his receipt.

Date _____ Applicant _____

Agent _____ Agent's License No. _____

Conditional Receipt

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CIGNA

Received of _____ Dollars

to be applied against the first premium on the proposed Group Insurance under this Application. This payment is made and accepted subject to the following conditions. Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect as of the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If the Application is not accepted, no insurance will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

Date _____ Agent _____ Agent's License No. _____

DETACH THIS RECEIPT WHEN PAYMENT IS MADE

Mailing Address: Hartford, Connecticut 06152
Home Office: Bloomfield, Connecticut

CIGNA HEALTH AND LIFE INSURANCE COMPANY

POLICYHOLDER: Arkansas LEA Filing Project Policy Specimen

ADDRESS: Little Rock, Arkansas

ACCOUNT NUMBER: 2926655

Group Insurance Policy and Policy Number	Effective Date	Anniversary Date
PREFERRED PROVIDER MEDICAL BENEFITS 2926655-ARKMGT	04/01/2010	April 1
PRESCRIPTION DRUG BENEFITS 2926655-ARKMGT	04/01/2010	April 1
CIGNA VISION 2926655-ARKMGT	04/01/2010	April 1
CIGNA TRADITIONAL DENTAL INSURANCE 2926655-ARKMGT	04/01/2010	April 1

(This listing of the Group Insurance Policies is continued on the next page.)

These Policies contain the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

Shermona Mapp, Secretary

Matthew G. Manders, President

Wilbur E. Parsell, Registrar

(Continued)

POLICYHOLDER: Arkansas LEA Filing Project Policy Specimen

Group Insurance Policy and Policy Number	Effective Date	Anniversary Date
PREFERRED PROVIDER MEDICAL BENEFITS 2926655-ARKSAL	04/01/2010	April 1
PRESCRIPTION DRUG BENEFITS 2926655-ARKSAL	04/01/2010	April 1
CIGNA VISION 2926655-ARKSAL	04/01/2010	April 1
CIGNA TRADITIONAL DENTAL INSURANCE 2926655-ARKSAL	04/01/2010	April 1
PREFERRED PROVIDER MEDICAL BENEFITS 2926655-ARKHR	04/01/2010	April 1
PRESCRIPTION DRUG BENEFITS 2926655-ARKSAL	04/01/2010	April 1
CIGNA VISION 2926655-ARKHR	04/01/2010	April 1
CIGNA TRADITIONAL DENTAL INSURANCE 2926655-ARKHR	04/01/2010	April 1

These policies are issued in Arkansas and shall be governed by its laws.

Arkansas state law requires insurers to deliver the following notice to policyholders.

ARKANSAS LIFE AND DISABILITY INSURANCE
GUARANTY ASSOCIATION NOTICE

Residents of this state who purchase life insurance or disability insurance or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The Arkansas Life and Disability Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the Insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

If you have additional questions, you should first contact your insurer or agent and then may contact:

Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 W Capital Avenue
Little Rock, Arkansas 72201

OR

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Disability Insurance Guaranty Association Act. Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or disability insurance contract, or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state. (This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation (FPBC) (whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer’s obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than the insurance company would owe under a policy or contract. Also, for any one insured’s life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values — again, no matter how may policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CONTENTS

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy(ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

GROUP POLICY(IES)		EMPLOYEE CLASS	
Certificate Number	Policy(ies)	Eligible Employees	Effective Date
CN001	Preferred Provider Medical Benefits Prescription Drug Benefits CIGNA Vision Care Insurance CIGNA Traditional Dental Insurance	Each Management Employee as reported to the insurance company by your Employer	April 1, 2010
CN002	Preferred Provider Medical Benefits Prescription Drug Benefits CIGNA Vision Care Insurance CIGNA Traditional Dental Insurance	Each Union Hourly Employee as reported to the insurance company by your Employer	April 1, 2010
CN003	Preferred Provider Medical Benefits Prescription Drug Benefits CIGNA Vision Care Insurance CIGNA Traditional Dental Insurance	Each Sales Employee as reported to the insurance company by your Employer	April 1, 2010

THE INSURANCE SCHEDULE (Continued)

GROUP POLICY(IES)		EMPLOYEE CLASS	
Certificate Number	Policy(ies)	Eligible Employees	Effective Date
CN004	Preferred Provider Medical Benefits Prescription Drug Benefits CIGNA Vision Care Insurance CIGNA Traditional Dental Insurance	Each Other Salaried Employee as reported to the insurance company by your Employer	April 1, 2010 !
CN005	Preferred Provider Medical Benefits Prescription Drug Benefits CIGNA Vision Care Insurance CIGNA Traditional Dental Insurance	Each Non-Union Hourly Employee as reported to the insurance company by your Employer	April 1, 2010

THE INSURANCE SCHEDULE (Continued)

The Certificate may include Certificate Riders which are identified by Rider Numbers. These Certificate Riders are listed below.

Certificate Rider Number	Certificate Number
!	

AFFILIATED EMPLOYERS

ELIGIBILITY FOR EMPLOYEE INSURANCE

Each Employee in one of the Classes of Eligible Employees shown below will become eligible for Employee Insurance according to the provisions set forth in the ELIGIBILITY - EFFECTIVE DATE section of the Employee Certificate.

AFFILIATED EMPLOYERS

!

WAITING PERIOD

!

CLASSES OF ELIGIBLE EMPLOYEES

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the policy becomes effective. If the Policyholder and the Insurance Company agree that premiums will be paid on a quarterly, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the policy will be cancelled except as set forth in the Grace Period.

MONTHLY STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semiannual or annual basis, the Monthly Statement Date will be the day in each month with the same number as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date for the time from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that (1), (2) or (3) below takes place.

(1) A person becomes insured.

(2) The amount of insurance on a person changes, but not due to a revision of The Schedule.

(3) A person ceases to be insured.

PREMIUMS (Continued)

MONTHLY PREMIUM RATE FOR MEDICAL EXPENSE INSURANCE. The monthly premium rate for Medical Expense Insurance is determined by written agreement between the Policyholder and CIGNA Health and Life Insurance Company.

MEDICAL EXPENSE INSURANCE PREMIUM. The monthly premium for Medical Expense Insurance will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.

(2) Add the results.

PREMIUMS (Continued)

MONTHLY PREMIUM RATE FOR DENTAL INSURANCE. The monthly premium rate for Dental Insurance is determined by written agreement between the Policyholder and CIGNA Health and Life Insurance Company.

DENTAL INSURANCE PREMIUM. The monthly premium for Dental Insurance will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
(2) Add the results.

PREMIUMS (Continued)

MONTHLY PREMIUM RATE FOR VISION CARE INSURANCE. The monthly premium rate for Vision Care Insurance is determined by written agreement between the Policyholder and CIGNA Health and Life Insurance Company.

VISION CARE INSURANCE PREMIUM. The monthly premium for Vision Care Insurance will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.

(2) Add the results.

PREMIUMS (Continued)

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. All results are taken to the nearer cent. If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by 15% or more.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees.

PREMIUMS (Continued)

CHANGES IN PREMIUM RATES (Continued)

(The following is applicable to Medical Expense, Dental and Vision Care Insurance)

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

(The following is applicable to Medical Expense Insurance)

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by interaction with an HMO.

The experience for the insurance under this policy for persons who are age 65 or older and for whom Medicare is the primary payer to this plan may be combined with the experience under other policies issued by the Insurance Company providing similar insurance for such persons.

Experience for Pooled Coverage under this policy may be combined with the experience for coverage which is deemed pooled under other group insurance policies providing similar insurance issued by the Insurance Company.

POOLED COVERAGE. Pooled Coverage means any benefits paid for a person in a policy year while this coverage is in force after benefits totaling $150,000 have already been paid in that year for him.

CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before the date.

The Insurance Company may cancel the policy due to the following reasons only:

with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable state or federal law;

as of any Premium Due Date, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;

immediately, if the Employer has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;

as of any Premium Due Date, if the number of insured Employees or if the number of insured Dependents fails to meet the minimum required per group participation rules; or for failure to comply with any other material plan provision relating to Employer contributions or group participation rules;

if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable state or federal law;

in accordance with any applicable state law, if it is determined that the size of the Employer group has changed, making such group eligible for a guaranteed issued small group product;

in accordance with any applicable state or federal law, if prior notice is given to the Employer;

as to an Employer member of an association to which this policy is issued, when the Employer's membership in the association ceases, in accordance with applicable state or federal law.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this policy may be modified to reflect product revisions which have been uniformly made to this product.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be canceled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the policy will automatically be canceled at the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be canceled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

MEDICAL CONVERSION PRIVILEGE

COST OF CONVERSION. In the event an eligible insured Employee or Dependent elects to be insured under an individual policy of medical care benefits (called a Converted Policy), in addition to the premium charged to the insured, the Insurance Company charges its group customers a one-time fee per each Conversion Policy issued.

The fee is due and payable upon issuance of coverage, and the charge may not be passed on to the applying individual or dependents.

The Insurance Company reserves the right to change the fee. If the fee changes, it will be effective on the policy anniversary date, and you will be notified in advance.

MISCELLANEOUS PROVISIONS

ADDITIONAL PROGRAMS. The Insurance Company may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact the Insurance Company for details of these programs.

PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of which is attached to the policy and all subsequent versions of the policy, and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

PROVISIONS (Continued)

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

PROVISIONS (Continued)

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Employee or Dependent must be given to the Insurance Company within (60) days of the loss of eligibility. If such notice is not received by the Insurance Company within (60) days of the date of loss of eligibility for an Employee or Dependent, then the Employer shall be responsible for all claims for that Employee or Dependent incurred through the (60th) day prior to the Insurance Company's receipt of notice of termination of eligibility for the Employee or Dependent.

CIGNA Health and Life Insurance Company

AMENDMENT

POLICYHOLDER: [ABC Company]

POLICY NUMBER: [A1234567]

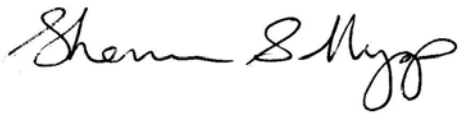
EFFECTIVE DATE OF THIS AMENDMENT: [September 1, 2010]

[**ISSUE DATE:** [September 1, 2010]]

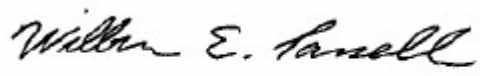
As of the Effective Date of this Amendment, the Policy specified above is amended by the provisions shown below:

[Insert specific amendatory text here.]

CIGNA HEALTH AND LIFE INSURANCE COMPANY



Shermona Mapp, Corporate Secretary



Wilbur E. Parsell, Registrar

ACCEPTED BY:

_____ _____

Policyholder Representative Title

_____

Date

RIDER

POLICYHOLDER: [ABC Company]

POLICY NUMBER: [A1234567]

EFFECTIVE DATE OF RIDER: [September 1, 2010]

ISSUE DATE OF RIDER: [September 1, 2010]

This Rider is subject to all terms of the policy except those specifically changed by this Rider.

1. The following definitions apply to the policy and this Rider:

   a. "Plan" means the plan established by the Policyholder for a certain Class of Employees.

   b. "Plan Benefits" means the Benefits in the Plan that are listed below for each Class of Employees.

		Rate Per Employee	
Class of Employees	Benefit	For Employee Insurance	For Dependent Insurance
[Each Employee]	[Other Medical Benefits]	$[XXX.XX]	$[XXX.XX]

   c. "Policy Month" means the period starting on a monthly Premium Due Date and ending on the day before the next monthly Premium Due Date; except that the first Policy Month starts on the Effective Date of this Rider and the last Policy Month ends on the day this Rider terminates.

   d. "Monthly Amounts" for each Class of Employees for each Benefit means the amount for any Policy Month that equals the number of Employees in that class multiplied by its Rate per Employee for that Policy Month for that Benefit.

   e. "Policy Year" means the period starting on a policy Anniversary Date and ending on the day before the next policy Anniversary Date; except that the first Policy Year starts on the Effective Date of this Rider and the last Policy Year ends on the day this Rider terminates.

   f. "Maximum Monthly Payment" for each Policy Month means the sum, for that Policy Month, of the Monthly Amount for each Class of Employees for each Benefit listed in item 1. b.

   g. "Maximum Yearly Payment" for each Policy Year means the sum of the Maximum Monthly Payments for each Policy Month in that Policy Year.

   h. "Benefit Payment Account" means the bank account of the Policyholder from which Plan Benefit payments for which he is liable are made.

2. The Policyholder is liable each Policy Month for payment of all Plan Benefits up to the sum of:

   a. the greater of:

      (i) the Maximum Monthly Payment for that month; or

(ii) 95% of the Maximum Monthly Payment for the preceding Policy Month; and

b. any excess of:

(i) the sum of the Maximum Monthly Payments for each preceding Policy Month of the current Policy Year; over

(ii) the sum of the Plan Benefits paid by the Policyholder in such Policy Months.

3. The Insurance Company, acting for the Policyholder, will:

a. determine the amount of any Plan Benefits that an Employee may be entitled to under item (2) above;

b. pay all Plan Benefits so determined; and

c. defend any action brought in connection with any claim for Plan Benefits so determined and make such settlement as it deems appropriate.

4. The Insurance Company will perform its duties as agent for the Policyholder with reasonable care and diligence and will be liable for any action not taken in good faith.

The Policyholder will not sustain any loss with respect to this Rider because of the dishonest, fraudulent or criminal acts of any employee of the Insurance Company.

5. During any Policy Month the Insurance Company is obligated to pay all Plan Benefits that exceed the Plan Benefits the Policyholder has to pay during that Policy Month.

6. The Insurance Company will determine the amount of any Plan Benefits which an Employee may be entitled to under item (5) above. It will defend any action brought in connection with any claim for Plan Benefits so determined and make such settlement as it deems appropriate.

7. The Policyholder will carry out his obligation to pay Plan Benefits as described in item (2) above by providing sufficient funds in the Benefit Payment Account to pay from it all benefits payable by him under the Plan in a timely manner.

8. An Employee making a claim for Plan Benefits shall submit such claim to the Insurance Company, subject to the policy requirements relating to Notice of Claim and Proofs of Loss.

9. When any claim for Plan Benefits has been approved, the Insurance Company will determine if such claim or any part of it is an obligation of the Policyholder or of the Insurance Company. Payment of such claim will be made in accordance with this determination which, where made in good faith, will be binding on the Insurance Company and the Policyholder.

10. If any payment is approved in relation to a contested claim, the Insurance Company will determine, based on the date payment is actually made, if such payment or any part of it is an obligation of the Policyholder or of the Insurance Company. Benefit payments made in accordance with the terms of any judgement or settlement will be deemed benefits paid to Employees under the Plan for the month in which such judgement or settlement is satisfied.

11. The obligations of the Insurance Company and the Policyholder under this Rider will be mutually exclusive and neither party will be liable for the obligations of the other.

12. The Monthly Premium Rate in the Policy will not apply to any Class of Employees and Benefits affected by this Rider. Instead, the following will be used:

		Rate Per Employee	
Class of Employees	Benefit	For Employee Insurance	For Dependent Insurance
[Each Employee[other than those age 65 or older for whom Medicare is primary payer]]	[Other Medical Benefits]	$[XXX.XX]	$[XXX.XX]

[The Experience Protection Benefit is not affected by this Rider; the Monthly Premium Rate in the policy will continue to apply to this benefit.] [Persons age 65 or older for whom Medicare is the primary payer to this plan are not affected by this Rider; the Monthly Premium Rate in the policy will continue to apply to these benefits.]

13. In addition to the premium determined in accordance with item (12) above, a Supplemental Premium will be due on each Monthly Premium Due Date. Payment of such Supplemental Premium will be waived contemporaneously with a subsequent Monthly Supplemental Premium becoming due. The Supplemental Premium outstanding at termination of this Rider will be payable on the date of such termination.

    The amount of the Supplemental Premium will be determined by use of a formula agreed upon by the Insurance Company and the Policyholder. In no event will the Supplemental Premium be greater than the amount which the Insurance Company would have accrued in accordance with its normal underwriting practices but for this Rider for both reserves and for premium taxes and expenses associated with claim payments issued after this Rider terminates.

14. The Insurance Company has the right to change the Monthly Premium Rate, the Supplemental Premium, the Monthly Amount, and the Maximum Monthly Payment as of: (a) any policy Anniversary Date; (b) the date of any change in the Plan; (c) except for the Supplemental Premium, the date this Rider terminates; and (d) at such other times as are provided for in the policy.

15. This Rider will automatically terminate on the earliest date below:

    a. the date the Plan ends;

    b. the close of the third consecutive business day during which the Policyholder has failed to provide sufficient funds in the Benefit Payment Account to pay Plan Benefits as they arise. (For the purposes of this item, the close of business on any day will occur at any time when deposits made to the Benefit Payment Account on that day will be credited to it as of the next business day by the bank in which the Benefit Payment Account is maintained.);

    c. the date the policy terminates.

    In any case this Rider may be terminated by: (a) the Policyholder, on any Premium Due Date, if he

gives written notice in advance of that date to the Insurance Company; and (b) the Insurance Company, at any time, if it gives the Policyholder 31 days' advance notice.

16. When this Rider terminates, the sum of (a), (b) and (c) below will be due and payable without delay by the Policyholder to the Insurance Company;

    a. all unpaid monthly premiums;

    b. the Supplemental Premium; and

    c. any excess of:

        (i) the sum of the Maximum Monthly Payments for each of the Policy Months in the last Policy Year, over

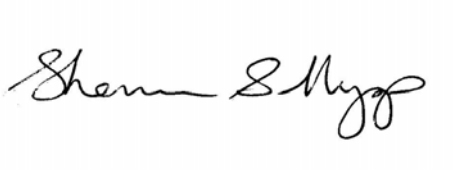
        (ii) the sum of:

            (a) all Plan Benefits the Policyholder has paid for such Policy Year; and

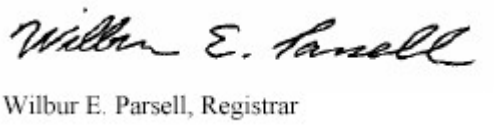
            (b) all Plan Benefits not yet paid at the time of such termination which the Policyholder must pay under the terms of this Rider for such Policy Year.

17. When this Rider terminates, the Policyholder will be responsible for the payment of all Plan Benefits for which checks were issued on the Benefit Payment Account before this Rider terminated, but not for payment of any other Plan Benefits under this Rider after its termination.

CIGNA HEALTH AND LIFE INSURANCE COMPANY



Shermona Mapp, Corporate Secretary



Wilbur E. Parsell, Registrar

ACCEPTED BY:

_____ _____

Policyholder Representative Title

_____

Date

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Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a CIGNA company (hereinafter called CIGNA) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: [ABC Company]

GROUP POLICY(S) — [MEDICAL BENEFITS] [MEDICAL AND VISION BENEFITS] COVERAGE [A1234567]

EFFECTIVE DATE: [September 1, 2010]

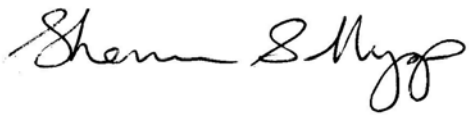
[NOTICE

Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.]

[NOTICE

This certificate does not apply to any employees unless this space is covered by a sticker indicating the employee's name and the certificate date.]

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.



Shermona Mapp, Corporate Secretary

Special Plan Provisions

[**When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider.**] Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Special Plan Provisions

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

   Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended

Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. [We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder.] Contact us for details regarding any such arrangements.

Special Plan Provisions

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

Special Plan Provisions

Notice Regarding Emergency Services and Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for Emergency Services, but you need to call your PCP [(if you have selected one)]or the CIGNA HealthCare 24-Hour Health Information Line] as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a Hospital admission, your PCP [(if you have selected one) or the CIGNA HealthCare 24-Hour Health Information Line] will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization may arrange to have you transferred to a Participating Provider for continuing or follow-up care, if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area

For Urgent Care inside the service area, you must take all reasonable steps to contact your PCP [(if you have selected one) or the CIGNA HealthCare 24-Hour Health Information Line] for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP [(if you have selected one)] or the Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP [(if you have selected one)] or the CIGNA HealthCare 24-Hour Health Information Line for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment

Continuing or follow-up treatment, whether in or out of the service area is not covered unless it is provided or arranged for by your PCP [(if you have selected one), a Participating Provider] or upon prior authorization by the Review Organization.

DISCLOSURE NOTICE

NOTICE: AS PERMITTED BY §23-79-803, THE POLICYHOLDER HAS SELECTED THIS PLAN WHICH DOES NOT PROVIDE COVERAGE IN ACCORDANCE WITH ONE, SOME OR ALL OF THE REQUIREMENTS FOR ONE OR MORE BENEFITS MANDATED BY THE STATUTES OF THE STATE OF ARKANSAS

STATE MANDATED BENEFITS NOT COVERED IN WHOLE OR IN PART ARE AS FOLLOWS:

Note: Refer to your Policy or Certificate of Insurance for details about covered expenses, non-covered expenses and limited covered expenses. Inclusion on this Disclosure Notice list may not mean that the benefit or service is not covered, but only that coverage may differ in some respect from the statutory requirements:

[Arkansas Mental Health Parity Act, §23-99-501, et. Seq.

Prescription drug benefit, §23-79-149

Provisions generally, unlicensed professionals ("Freedom of Choice") §23-79-114 and Bulletin 9-85]

You are urged to contact your health insurance agent or the Arkansas Insurance Department Consumer Affairs or Legal Division about questions or concerns related to the nature of the state mandated health benefit which is not provided in this health benefits plan.

[HOW TO FILE YOUR CLAIM

[There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to [CIGNA] for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf.] [If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims.] [Claims can be submitted by the provider if the provider is able and willing to file on your behalf.] If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling [Member Services] using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE [CIGNA's] CLAIM FORMS, OR WHEN YOU CALL YOUR [CIGNA] CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM [TO CIGNA].

TIMELY FILING [**OF OUT-OF-NETWORK CLAIMS**]

[CIGNA] will consider claims for coverage under our plans when proof of loss (a claim) is submitted within [one year (365 days)] [180 days for In-Network benefits and one year (365 days) for Out-of-Network benefits] after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within [one year] [180 days for In-Network benefits and one year (365 days) for Out-of-Network benefits], the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.]

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least [15-40] hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the [New Employee Group] Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within [30 days-one year] after your insurance ceased.

[Initial Employee Group: You are in the Initial Employee Group if you are [employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer] [in the employ of an Employer on the Participation Date of the Employer].

New Employee Group: You are in the New Employee Group if [you are not in the Initial Employee Group] [your Employment with an Employer starts after the Participation Date of that Employer].]

[**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.]

Waiting Period

Initial Employee Group: [None] [[1-90] Days]

New Employee Group: [None] [[1-90 days] after date of hire] [[1-90] days from the date of Active Service] [First of the month following [1-90] days from the date of Active Service] [The first day of the month following [1-90] days from date of hire]

Classes of Eligible Employees

[Each Employee as reported to the insurance company by your Employer.]

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. [If you are a Late Entrant, your insurance will not become effective until CIGNA agrees to insure you.]

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of good health to be provided at your expense if you are a Late Entrant.

[Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CIGNA agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of your Dependent's good health at your expense if you are a Late Entrant.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90 days after his birth. If you do not elect to insure your newborn child within such 90 days, coverage for that child will end on the 90th day. No benefits for expenses incurred beyond the 90th day will be payable.]

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least [15-40] hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the [New Employee Group] Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within [30 days-one year] after your insurance ceased.

[Initial Employee Group: You are in the Initial Employee Group if you are [employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer] [in the employ of an Employer on the Participation Date of the Employer].

New Employee Group: You are in the New Employee Group if [you are not in the Initial Employee Group] [your Employment with an Employer starts after the Participation Date of that Employer].]

[**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.]

Waiting Period

Initial Employee Group: [None] [[1-90] Days]

New Employee Group: [None] [[1-90 days] after date of hire] [[1-90] days from the date of Active Service] [First of the month following [1-90] days from the date of Active Service] [The first day of the month following [1-90] days from date of hire]

Classes of Eligible Employees

[Each Employee as reported to the insurance company by your Employer.]

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. [If you are a Late Entrant, your insurance will not become effective until CIGNA agrees to insure you.]

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of good health to be provided at your expense if you are a Late Entrant.

[Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CIGNA agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of your Dependent's good health at your expense if you are a Late Entrant.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90~~31~~ days after his birth. If you do not elect to insure your newborn child within such 90~~31~~ days, coverage for that child will end on the 90th~~31st~~ day. No benefits for expenses incurred beyond the90th ~~31st~~ day will be payable.]

ELIGIBILITY — EFFECTIVE DATE

Eligibility for Employee Insurance

You will become eligible for Supplemental Medical Benefits on the day you are eligible under your Employer-Sponsored Medical[, Dental and Vision] Benefits Plan(s) if you are in a Class of Eligible Employees.

[Eligibility for Dependent Insurance

You will become eligible for Supplemental Medical Benefits for Dependents on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.]

Classes of Eligible Employees

[Each Employee as reported to the insurance company by your Employer.]

Employee Supplemental Medical Benefits

This Plan is offered to you as an Employee.

Effective Date of Your Supplemental Medical Benefits

You will become insured on the date you elect the insurance by signing an approved payroll deduction form (if required), but no earlier than the date you become eligible.

[Dependent Supplemental Medical Benefits

For your Dependents to be insured, you may have to pay part of the cost of Dependent Supplemental Medical Benefits.

Effective Date of Your Supplemental Medical Benefits for Your Dependents

Supplemental Medical Benefits for your Dependents will become effective on the date you elect them by signing an approved payroll deduction form (if required), but no earlier than the date you become eligible for them. All of your Dependents as defined by the terms of your Employer-Sponsored Medical[, Dental and Vision] Benefits Plan(s) will be included.

Your Dependents will be insured only if you are insured.]

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by CIGNA for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

Details of your medical benefits are described on the following pages.

[**Opportunity to Select a**] **Primary Care Physician**

Choice of Primary Care Physician:

When you elect Medical Insurance, you [will] [may] select a Primary Care Physician for yourself and your Dependents from a list provided by CIGNA. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/[Your Responsibility] [Direct Access to Participating Physicians]:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

[You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)]

[However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.]

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

[In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.]

[DIRECT ACCESS FOR OB/GYN SERVICES

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered OB/GYN services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.]

[**DIRECT ACCESS FOR CHIROPRACTIC CARE SERVICES**

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for Chiropractic Care.]

[Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits

The Schedule

For You [**and Your Dependents**]

[Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive [Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

[**Copayments/Deductibles**

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. [Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.]]

Out of Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- [inpatient hospital facility copayments or deductibles.]
- [outpatient facility copayments or deductibles.]
- [MRI/MRA/CAT/PET Scan copayments or deductibles.]

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- [Mental Health and Substance Abuse treatment.]
- non-compliance penalties.
- [provider charges in excess of the Maximum Reimbursable Charge.]

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- [Mental Health and Substance Abuse treatment.]
- non-compliance penalties.
- [provider charges in excess of the Maximum Reimbursable Charge.]

[**Note:**
Refer to your CIGNA Choice Fund Member Handbook for information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan.]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

[Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, [Out-of-Network will accumulate to In-Network] [In-Network will accumulate to Out-of-Network]). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]

[Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). However, all other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[**Contract Year**

Contract Year means a twelve month period beginning on each [Month] [Date].]

[**Guest Privileges**

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.]

[**Assistant Surgeon and Co-Surgeon Charges**

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[Lifetime Maximum for essential benefits	Unlimited]	
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]	[$10,000-Unlimited]]
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for essential benefits**	[$750,000 - Unlimited]]	
[**Annual Maximum for essential benefits**	[$750,000 - Unlimited]	[$750,000 - Unlimited]]
[**Annual Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for non-essential benefits**	[Not Applicable] [$10,000-Unlimited]	[$10,000-Unlimited]
Coinsurance Levels	[50-100]%	[30-80]% [of the Maximum Reimbursable Charge]
[**Maximum Reimbursable Charge** Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or		
[A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database CIGNA has selected.	Not Applicable	[70-90]th Percentile]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[[**Medical charges**] [A percentage of a fee schedule that CIGNA has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the [70-90]th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA. (excludes Mental Health and Substance Abuse)	Not Applicable	[110] [150] [200]%]
[**Mental Health And Substance Abuse** A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database CIGNA has selected.	Not Applicable	[70-90]th Percentile]
Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Automatic Reinstatement** The total amount of Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule. However, once a person uses any portion of his Maximum Benefit, on each January 1, CIGNA will reinstate the used amount up to $[1,000-5,000] to be applied to Covered Expenses incurred after the date of reinstatement.]		
[[**Contract**] [**Calendar**] **Year Deductible** Individual	[$[0-10,000] per person] [Not Applicable]	[$[0-10,000] per person] [Not Applicable]
Family Maximum	[$[0-30,000] per family] [Not Applicable]	[$[0-30,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.]		
[Family Maximum Calculation **Individual Calculation** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]		
[**Combined Medical/Pharmacy** [**Contract**] [**Calendar**] **Year**		
Combined Medical/Pharmacy Deductible: includes retail and mail order drugs	[No] [Yes]	[No] [Yes]
Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	[No] [Yes]	[No] [Yes]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[RX cap contribution to the combined Medical/Pharmacy Deductible **Note:** Once the RX cap amount or the combined Medical/Pharmacy deductible has been met, the terms of the Pharmacy plan benefits are applicable.	$[0-900]	$[0-900]]
[**Out-of-Pocket Maximum**		
Individual	[$[0-30,000] per person] [Not Applicable]	[$[0-90,000] per person] [Not Applicable]
Family Maximum	$[0-90,000] per family [Not Applicable]	[$[0-90,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family deductible has been satisfied.]		
[Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.]		
[**Combined Medical/Pharmacy Out-of-Pocket Maximum**		
Combined Medical/CIGNA Pharmacy Out-of-Pocket: includes retail and mail order drugs	[No] [Yes]	[No] [Yes]
Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	[No] [Yes]	[No] [Yes]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[RX cap contribution to the combined Medical/Pharmacy Out-of-Pocket maximum Once the RX cap amount has been met or the total Out of Pocket maximum has been met, the terms of the Pharmacy plan benefits are applicable and subject to: Option 1: Pharmacy paid at 100% once the cap amount has been met. Option 2: Pharmacy continued to be paid at the Pharmacy Program levels (i.e. copay, coinsurance)	$[0-30,000]	$[0-30,000]]
Physician's Services		
Primary Care Physician's Office visit	[No charge after $[0-100] per office visit copay; No charge after the PCP per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist, depending on how the provider contracts with CIGNA.]	[No charge after $[0-150] Specialist per office visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]]
Surgery Performed In the Physician's Office	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]]
Second Opinion Consultations (provided on a voluntary basis)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]]
Allergy Treatment/Injections	[No charge after either the $[0-100] PCP or $[0-150] Specialist per office visit copay or the actual charge, whichever is less] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[20-1,000]]
Allergy Serum (dispensed by the Physician in the office)	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible] [not to exceed $[20-1,000]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Preventive Care** Routine Preventive Care : Well-Baby, Well-Child, Adult and Well-Woman (including immunizations) [**Note:** Well-Woman OB/GYN visits will be considered a Specialist visit.] [[Contract] [Calendar] Year Maximum: [$250-Unlimited]]	No charge	[No charge] [30-80]% after plan deductible]
[**Routine Preventive Care after** [**Contract**] [**Calendar**] **Year Maximum is reached**	No charge	[No charge]
Preventive X-ray and/or Lab Services	No charge	[No charge] [30-80]% after plan deductible]
Immunizations	No charge]	[No charge] [30-80]% after plan deductible]
[**Preventive Care** [[Contract] [Calendar] Year Maximum through age 2 (including immunizations): Unlimited] [[Contract] [Calendar] Year Maximum [for ages 3 and above [(including] [excluding] immunizations)]: [$250-Unlimited]] [**Note:** Well-woman OB/GYN visits will be considered [either] a [PCP or] Specialist visit [depending on how the provider contracts with CIGNA].] [**Note:** Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.]]		
Physician's Office Visit	No charge	[No charge] [30-80]% after plan deductible]
Immunizations	No charge	[No charge] [30-80]% after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, PAP Smear		
[**Notes:** • Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. • PSA and Pap Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. • PSA and Pap Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum.] • [All Mammogram, PSA and Pap Smear charges, when billed as a preventive care related service, accumulate to the plan's Preventive Care dollar maximum, regardless of place of service.].		
Preventive Care Related Services (i.e. "routine" services)	No charge	[No charge [after plan deductible]] [[30-80]% [after plan deductible]]
[Diagnostic Related Services (i.e. "non-routine" services)	[No charge [after plan deductible]] [[50-100]% after plan deductible if billed by an independent diagnostic facility or outpatient hospital] [[50-100]% [after plan deductible]]	[No charge [after plan deductible]] [[30-80]% [after plan deductible]]]
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service]
	[**Note:** The associated wellness exam will be covered at no charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [**Note:** The associated wellness exam is subject to the $[0-100] PCP or $[0-150] Specialist per office visit copay]	[**Note:** The associated wellness exam is not covered]
Inpatient Hospital - Facility Services	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Semi-Private Room and Board	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private negotiated rate	Limited to the semi-private room rate

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The [facility copay] [facility deductible] [facility copay or facility deductible] will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the [facility copay] [facility deductible] [facility copay or facility deductible].]	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Inpatient Hospital Physician's Visits/Consultations	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Inpatient Hospital Professional Services	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
[Surgeon Radiologist Pathologist Anesthesiologist	[50-100]% [after plan deductible]	[30-80]% after plan deductible]
Outpatient Professional Services	[No charge] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[Surgeon Radiologist Pathologist Anesthesiologist	[50-100]%[after plan deductible]	[30-80]% after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed [[50-100]% [after plan deductible]]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]
Hospital Emergency Room	[No charge after $[0-500] per visit copay* [and plan deductible] *Copay waived if admitted] [No charge] [[50-100]% [after plan deductible]]	[No charge after $[0-500] per visit copay* [and plan deductible] (*Copay waived if admitted)] [No charge] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]
Outpatient Professional services (radiology, pathology and ER Physician)	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[No charge [after plan deductible]] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]
Urgent Care Facility or Outpatient Facility	[No charge after $[0-250] per visit copay* [and plan deductible] *Copay waived if admitted] [No charge] [[50-100]% [after plan deductible]]	[No charge after $[0-250] per visit copay* [and plan deductible] *Copay waived if admitted] [No charge] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]] [[30-80]% [after plan deductible]]
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	[No charge] [[50-100]% [after plan deductible]]	[No charge] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]
Independent x-ray and/or Lab Facility in conjunction with an ER visit	[No charge] [[50-100]% [after plan deductible]]	[No charge] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans [and Nuclear Medicine] etc.) [The scan copay[/deductible] applies per type of scan per day]	[No charge [after $[0-500] scan copay]] [$[0-500] scan copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[No charge [after $[0-500] scan copay]] [$[0-500] scan copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible] [(except if not an emergency, then [30-80]% after plan deductible)]]
Ambulance	[No charge[**]] [[50-100]% after plan deductible] [not to exceed $500-30,000] [**] [** If not a true emergency, services are not covered]	[No charge[**]] [[50-100]% after plan deductible] [not to exceed $500-30,000] [**] [[50-100]% after plan deductible (except if not an emergency, then [30-80]% after plan deductible)] [** If not a true emergency, services are not covered]
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [[30-Unlimited] days combined] [[30-Unlimited] days for Skilled Nursing Facility; [30-Unlimited] days for Rehabilitation Hospital; [30-Unlimited] days for Sub-Acute Facilities] [No prior hospitalization required]	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible [not to exceed $[0-1,000]]
[**Laboratory and Radiology Services (includes pre-admission testing)** [**Advanced Radiological Imaging** **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]) [**Note:** [The copay/deductible applies on a per procedure basis, for any place of service (including inpatient facility, etc.)] [Associated ancillary charges are subject to the applicable place of service coinsurance level, place of service copay/deductible and/or plan deductible (e.g. injections, dye, etc.)]]	[[No charge [after $[0-1,000] per procedure copay] [$[0-1,000] per procedure copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-1,000] per procedure deductible, then [30-80]% after plan deductible] [[30-80]% [after plan deductible]]]
[**Other Laboratory and Radiology Services:**]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Office Visit	[No charge [after the $[0-100] PCP or $[0-150] Specialist per visit copay]] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Outpatient Hospital Facility	[No charge after plan deductible for facility charges; no charge for outpatient professional charges] [[50-100]% after plan deductible for facility charges; no charge for outpatient professional charges] [[50-100]% after the plan deductible for facility charges; [50-100]% after the plan deductible for outpatient professional charges] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Independent X-ray and/or Lab facility	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible]
[**Advanced Radiological Imaging** **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]**)** [The scan copay/deductible applies per type of scan per day]		
Physician's Office Visit	[No charge [after $[0-1,000] scan copay]] [No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [$[0-500] scan copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-1,000] scan deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Inpatient Facility	[No charge [after plan deductible]] [[50-100]% [after plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-1,000] scan copay [and plan deductible]] [No charge [after plan deductible]] [$[0-500] scan copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-1,000] scan deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Outpatient Short-Term Rehabilitative Therapy** [**and Chiropractic Services**] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [In-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [Out-of-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined]	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay [but not less than $[20-150]]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]] [**Note:** The Outpatient Short Term Rehab copay [does not apply to services provided as part of a Home Health Care visit] [applies, regardless of place of service, including the home].]	[[30-80]% after plan deductible]
Includes: [Cardiac Rehab] Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy [Chiropractic Therapy (includes Chiropractors)]]		
[**Outpatient Short-Term Rehabilitative Therapy**		
• **Outpatient Physical Therapy** [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible] [not to exceed $[0-1,000]]]
• **Outpatient Speech, Hearing and Occupational Therapy** [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible] [not to exceed $[0-1,000]]]]
[**Outpatient Cardiac Rehabilitation** [Contract] [Calendar] Year Maximum: [36-Unlimited] days	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[[**Self-Referral**] **Chiropractic Care Services** [[Contract] [Calendar] Year Maximum: [12-Unlimited] [visits] [days] [visits or days] [consecutive days per condition] [$[500-Unlimited]] Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay [but not less than $[20-150]]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible] [not to exceed $[0-1,000]]]
[**Home Health Care** [[Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary)] [In-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary) Out-of-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (reduced by any In-Network [days] [visits]; includes outpatient private nursing when approved as medically necessary)]	[No charge [after plan deductible]] [[50-100]% after plan deductible]	[[30-80]% after plan deductible] [not to exceed $[0-1,000]]]
[**Hospice** Inpatient Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Outpatient Services (same coinsurance level as Home Health Care)	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[Lifetime Maximum: $[5,000-Unlimited]]		
Bereavement Counseling Services Provided as part of Hospice Care		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Outpatient	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[Services Provided by Mental Health Professional	Covered under Mental Health benefit	[Covered under Mental Health benefit]]]
Maternity Care Services		
Initial Visit to Confirm Pregnancy [**Note:** OB/GYN providers will be considered [either] a [PCP or] Specialist [depending on how the provider contracts with CIGNA].	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible] [[30-80]% after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Abortion Includes [elective and] non-elective procedures		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
[**Family Planning Services**		
[Physician's Office Visit (tests, counseling)] [Office Visits, Lab and Radiology Tests and Counseling] [Maximum: subject to plan's Preventive Care dollar maximum] [**Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals):		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Office Visits	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible]
[**Infertility Treatment** Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination Services Not Covered include: In-vitro, GIFT, ZIFT, etc. [Surgical Treatment: Limited to procedures for the correction of infertility.]		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[Surgical Procedure Copay	[$[0-750] Surgical Copay [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[Lifetime Maximum: $[5,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Lifetime Maximum: $[10,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Inpatient Facility	[100% at Lifesource center after $[0-4,500] per admission copay, otherwise [50-100]% after $[0-4,500] per admission copay [and plan deductible]] [[50-100]% after $[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [100% at Lifesource center [after plan deductible], otherwise [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible up to transplant maximum] [[30-80]% after plan deductible [up to transplant maximum]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]] [100% at Lifesource center [after plan deductible], otherwise [50-100]% [after plan deductible]]	[30-80]% after plan deductible [up to specific organ transplant maximum: Heart - $[25,000-Unlimited] Liver - $[25,000-Unlimited] Bone Marrow -$[25,000-Unlimited] Heart/Lung - $[25,000-Unlimited] Lung - $[25,000-Unlimited] Pancreas - $[25,000-Unlimited] Kidney - $[25,000-Unlimited] Kidney/Pancreas - $[25,000-Unlimited]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Travel Maximum: $[10,000-Unlimited] per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only]
[**Durable Medical Equipment (including External Prosthetic Appliances)** [In-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [[Contract] [Calendar] Year Maximum: [$500-Unlimited]] [In-Network Lifetime Maximum: $[3,000-Unlimited]] [Out-of-Network Lifetime Maximum: $[3,000-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [**Note:** Services do accumulate to the plan's out-of-pocket maximum.]	[50-100]% [after plan deductible]	[[30-80]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Durable Medical Equipment** [In-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] Out-of-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] [[Contract] [Calendar] Year Maximum: $[700-Unlimited]] [**Note:** Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[No charge [after plan deductible]] [50-100]% [after plan deductible]]	[[30-80]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**External Prosthetic Appliances** [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [**Note:** [The EPA deductible will not accumulate to the plan Out-of-Pocket maximum.] Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[No charge [after $[0-500] EPA deductible per [Contract] [Calendar] Year]] [$[0-500] EPA deductible per [Contract] [Calendar] Year, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-500] EPA deductible per [Contract] [Calendar] Year, then [30-80]% after plan deductible] [[30-80]% after plan deductible]]
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible
[**TMJ Surgical and Non-surgical** Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[**Surgical and**] **Non surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Obesity/Bariatric Surgery** **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Inpatient Facility	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient Facility	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Lifetime Maximum: $[8,000-Unlimited] Coinsurance charges for obesity surgery will not accumulate to the plan Out-of-Pocket maximum.]		
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[No charge after the $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]]]
[**Routine Foot Disorders**	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Routine Foot Disorders**		
Physician's Office Visit [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited] Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]		
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]		
[**Mental Health**	[Not Covered]	[Not Covered]
Inpatient	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
[Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]	[30-80]% after plan deductible

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible] [[30-80]% after plan deductible]]
[Outpatient ▪ Includes Individual, Group and Intensive Outpatient ▪ Applies to Physician's Office and Outpatient Facility]	[No charge after the $[0-150] per visit copay] [No charge [after plan deductible]] [$[0-150] per visit copay [after plan deductible]] [[50-100]% [after plan deductible]]	[No charge [after plan deductible]] [$[0-4,500] per visit deductible [after plan deductible]] [$ [0-4,500] per visit deductible, then] [30-80]% [after plan deductible]] [[30-80]% [after plan deductible]]
[**Substance Abuse**] [**Chemical Dependency**]	[Not Covered]	[Not Covered]
Inpatient	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
[Outpatient (Includes Individual and Intensive Outpatient) Physician's Office Visit]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% after plan deductible]	[30-80]% after plan deductible
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[No charge after $[0-2,250] per visit copay [and plan deductible]] [$[0-2,250] per visit copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	$[0-4,500] per visit deductible, then [30-80]% after plan deductible [not to exceed $[500-100,000]] [[30-80]% after plan deductible]]
[Outpatient ▪ Includes Individual and Intensive Outpatient ▪ Applies to Physician's Office and Outpatient Facility]	[No charge after the $[0-150] per visit copay] [No charge [after plan deductible]] [$[0-150] per visit copay [after plan deductible]] [[50-100]% [after plan deductible]]	[No charge [after plan deductible]] [$[0-4,500] per visit deductible [after plan deductible]] [$ [0-4,500] per visit deductible, then][30-80]% [after plan deductible]] [[30-80]% after [plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Mental Health**	[Not Covered]	[Not Covered]
Inpatient [Contract] [Calendar] Year Maximum: [8-Unlimited] days [Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1] [Residential for Substance Abuse: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient [Contract] [Calendar] Year Maximum: [20-Unlimited] visits	[No charge after $[0-150] per office visit copay] [Visits 1-20: No charge after $[0-150] per office visit copay Visits 20-[Unlimited]: No charge after $[0-150] per office visit copay] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Outpatient Group Therapy [(One group therapy session equals one individual therapy session)] [[Contract] [Calendar] Year Maximum: [40-Unlimited] visits]	[No charge after $[0-100] per visit copay] [[50-100]% [after plan deductible]]	[[30-80]% after plan deductible]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Based on a ratio of 1:1	[[50-100]% after $[0-2,500] per program copay] [[50-100]% [after plan deductible]]	[[50-100]% after $[0-5,000] per program deductible] [[50-100]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[**Substance Abuse**] [**Chemical Dependency**]	[Not Covered]	[Not Covered]
Inpatient [Contract] [Calendar] Year Maximum: [8-Unlimited] days [Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1] [Residential for Substance Abuse: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[No charge after $[0-4,500] per admission copay [and plan deductible]] [$[0-4,500] per admission copay, then [50-100]% [after plan deductible]] [$[0-1,500] per day copay [up to [3-Unlimited] copays per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]	[$[0-9,000] per admission deductible, then [30-80]% after plan deductible [$[0-3,000] per day deductible [up to [3-Unlimited] deductibles per admission], then [30-80]% after plan deductible]] [[30-80]% after plan deductible]
Outpatient [Contract] [Calendar] Year Maximum: [20-Unlimited] visits	[No charge after $[0-150] per visit copay] [Visits 1-20: No charge after $[0-150] per office visit copay Visits 20-[Unlimited]: No charge after $[0-150] per office visit copay [First 2 visits: No charge after $[0-150] per visit copay Visits 3-[Unlimited]: No charge after $[0-150] per visit copay] [[50-100]% after plan deductible]	[[30-80]% after plan deductible]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Maximum: Each visit provided as part of a program accumulates to the Outpatient Substance Abuse benefit maximum on a 1:1 ratio basis with Outpatient Substance Abuse visits.	[[50-100]% after $[0-2,500] per program copay] [[50-100]% after plan deductible]	[[50-100]% after $[0-5,000] per program deductible] [[50-100]% after plan deductible]]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

Comprehensive Medical Benefits

The Schedule

For You [**and Your Dependents**]

To receive Comprehensive Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

[**Copayments**

Copayments are expenses to be paid by you or your Dependent for covered services. Copayments are in addition to any Coinsurance.]

[**Copayments/Deductibles**

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. [Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.]]

[**Deductibles**

Deductibles are expenses to be paid by you or your Dependent. Deductible amounts are separate from and are in addition to any Coinsurance. [Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.]

Out of Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- [inpatient hospital facility [copayments] [or] deductibles.]]
- [outpatient facility [copayments] [or] [deductibles.]]
- [MRI/MRA/CAT/PET Scan [copayments] [or] [deductibles.]]

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- [Mental Health and Substance Abuse treatment.]
- non-compliance penalties.
- [provider charges in excess of the Maximum Reimbursable Charge.]

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- [Mental Health and Substance Abuse treatment.]
- non-compliance penalties.
- [provider charges in excess of the Maximum Reimbursable Charge.]

[**Note:**
Refer to your CIGNA Choice Fund Member Handbook for information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan.]

[**Contract Year**

Contract Year means a twelve month period beginning on each [Month] [Date].]

[**Guest Privileges**

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Network Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.]

[**Assistant Surgeon and Co-Surgeon Charges**

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[Lifetime Maximum for essential benefits	Unlimited]
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]]
[**Annual Maximum for essential benefits**	[$750,000 - Unlimited]]
[**Annual Maximum for non-essential benefits**	[$10,000-Unlimited]]
Coinsurance Levels	[50-100]% [of the Maximum Reimbursable Charge]
[**Maximum Reimbursable Charge** Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or [A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database CIGNA has selected.	[70-90]th Percentile]
[A percentage of a fee schedule that CIGNA has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the [70-90]th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.	[110] [150] [200]%]
Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.]	

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Automatic Reinstatement** The total amount of Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule. However, once a person uses any portion of his Maximum Benefit, on each January 1, CIGNA will reinstate the used amount up to $[1,000-5,000] to be applied to Covered Expenses incurred after the date of reinstatement.]	
[[**Contract**] [**Calendar**] **Year Deductible** Individual	[$[0-10,000] per person] [Not Applicable]
Family Maximum	[$[0-30,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.]	
[Family Maximum Calculation **Individual Calculation** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]	
[**Combined Medical/Pharmacy** [**Contract**] [**Calendar**] **Year** Combined Medical/Pharmacy Deductible: includes retail and mail order drugs Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	[No] [Yes] [No] [Yes]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[RX cap contribution to the combined Medical/Pharmacy Deductible **Note:** Once the RX cap amount or the combined Medical/Pharmacy deductible has been met, the terms of the Pharmacy plan benefits are applicable.	$[0-900]]
[**Out-of-Pocket Maximum**	
Individual	[$[0-30,000] per person] [Not Applicable]
Family Maximum	[$[0-90,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family deductible has been satisfied.]	
[Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.]	
[**Combined Medical/Pharmacy Out-of-Pocket Maximum**	
Combined Medical/CIGNA Pharmacy Out-of-Pocket: includes retail and mail order drugs Mail Order Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	[No] [Yes] [No] [Yes]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[RX cap contribution to the combined Medical/Pharmacy Out-of-Pocket maximum Once the RX cap amount has been met or the total Out of Pocket maximum has been met, the terms of the Pharmacy plan benefits are applicable and subject to: Option 1: Pharmacy paid at 100% once the cap amount has been met. Option 2: Pharmacy continued to be paid at the Pharmacy Program levels (i.e. copay, coinsurance)	$[0-30,000]]
Physician's Services	
Primary Care Physician's Office visit	[No charge after $[0-100] per office visit copay; No charge after the PCP per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist, depending on how the provider contracts with CIGNA.]	[No charge after $[0-150] Specialist per office visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
Surgery Performed In the Physician's Office	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]
Second Opinion Consultations (provided on a voluntary basis)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]
Allergy Treatment/Injections	[No charge after either the $[0-100] PCP or $[0-150] Specialist per office visit copay or the actual charge, whichever is less] [[50-100]% [after plan deductible]]
Allergy Serum (dispensed by the Physician in the office)	[No charge] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Preventive Care** Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations) [**Note:** Well-Woman OB/GYN visits will be considered a Specialist visit.] [[Contract] [Calendar] Year Maximum: [$250-Unlimited]]	No charge
[**Routine Preventive Care after** [**Contract**] [**Calendar**] **Year Maximum is reached**	No charge
Preventive X-ray and/or Lab Services	No charge
Immunizations	No charge]
[**Preventive Care** [[Contract] [Calendar] Year Maximum through age 2 (including immunizations): Unlimited] [[Contract] [Calendar] Year Maximum [for ages 3 and above [(including] [excluding] immunizations)]: [$250-Unlimited]] [**Note:** Well-woman OB/GYN visits will be considered [either] a [PCP or] Specialist visit [depending on how the provider contracts with CIGNA].] [**Note:** Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.]]	
Physician's Office Visit	No charge
Immunizations	No charge]
Mammograms, PSA, PAP Smear	
[**Notes:** • Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. • PSA and Pap Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. • PSA and Pap Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum.] • [All Mammogram, PSA and Pap Smear charges, when billed as a preventive care related service, accumulate to the plan's Preventive Care dollar maximum, regardless of place of service.].	
Preventive Care Related Services (i.e. "routine" services)	No charge

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[Diagnostic Related Services (i.e. "non-routine" services)	[No charge] [No charge [after plan deductible]] [[50-100]% after plan deductible if billed by an independent diagnostic facility or outpatient hospital] [[50-100]% [after plan deductible]]]
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service]
	[**Note:** The associated wellness exam will be covered at no charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [**Note:** The associated wellness exam is subject to the $[0-100] PCP or $[0-150] Specialist per office visit copay]
Inpatient Hospital - Facility Services	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Semi-Private Room and Board	Limited to the semi-private negotiated rate
Private Room	Limited to the semi-private negotiated rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The copay will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the facility copay/deductible].	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Inpatient Hospital Physician's Visits/Consultations	[No charge] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Inpatient Hospital Professional Services [Surgeon Radiologist Pathologist Anesthesiologist]	[No charge] [[50-100]% [after plan deductible]]
Outpatient Professional Services [Surgeon Radiologist Pathologist Anesthesiologist]	[No charge] [[50-100]% [after plan deductible]]
Emergency and Urgent Care Services	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed [[50-100]% [after plan deductible]]
Hospital Emergency Room	[No charge after $[0-500] per visit [copay] [deductible]* [and plan deductible] *[Copay] waived if admitted] [No charge after $[0-500] per visit deductible*, then [50-100]% [after plan deductible] *waived if admitted] [No charge] [[50-100]% [after plan deductible]]
Outpatient Professional services (radiology, pathology and ER Physician)	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
Urgent Care Facility or Outpatient Facility	[No charge after $[0-250] per visit [copay] [deductible]* [and plan deductible] *[Copay] waived if admitted] [No charge after $[0-250] per visit deductible*, then [50-100]% [after plan deductible] *waived if admitted] [No charge] [[50-100]% [after plan deductible]]
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	[No charge] [[50-100]% [after plan deductible]]
Independent x-ray and/or Lab Facility in conjunction with an ER visit	[No charge] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans [and Nuclear Medicine] etc.) [The scan copay[/deductible] applies per type of scan per day]	[No charge [after $[0-500] scan copay]] [$[0-500] scan copay, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Ambulance	[No charge[**]] [[50-100]% after plan deductible] [not to exceed $500-30,000] [**] [** If not a true emergency, services are not covered]
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [[30-Unlimited] days combined] [[30-Unlimited] days for Skilled Nursing Facility; [30-Unlimited] days for Rehabilitation Hospital; [30-Unlimited] days for Sub-Acute Facilities] [No prior hospitalization required]	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[**Laboratory and Radiology Services (includes pre-admission testing)** [**Advanced Radiological Imaging** **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]**)** [**Note:** [The [copay] [deductible] applies on a per procedure basis, for any place of service (including inpatient facility, etc.)] [Associated ancillary charges are subject to the applicable place of service coinsurance level, place of service copay/deductible and/or plan deductible (e.g. injections, dye, etc.)]]	[[No charge [after $[0-1,000] per procedure [copay] [deductible]] [$[0-1,000] per procedure [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]]
[**Other Laboratory and Radiology Services:**]	

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Physician's Office Visit	[No charge [after the $[0-100] PCP or $[0-150] Specialist per visit copay]] [[50-100]% [after plan deductible]]
Outpatient Hospital Facility	[No charge after plan deductible for facility charges; no charge for outpatient professional charges] [[50-100]% after plan deductible for facility charges; no charge for outpatient professional charges] [[50-100]% after the plan deductible for facility charges; [50-100]% after the plan deductible for outpatient professional charges] [[50-100]% [after plan deductible]]
Independent X-ray and/or Lab facility	[No charge] [[50-100]% [after plan deductible]]]
[**Advanced Radiological Imaging** **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]**)** [The scan [copay] [deductible] applies per type of scan per day]	
Physician's Office Visit	[No charge [after $[0-1,000] scan [copay] [deductible]]] [No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [$[0-500] scan [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge [after plan deductible]] [[50-100]% [after plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-1,000] scan [copay] [deductible] [and plan deductible]] [No charge [after plan deductible]] [$[0-500] scan [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]]
[**Outpatient Short-Term Rehabilitative Therapy** [**and Chiropractic Services**] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined]	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay [but not less than $[20-150]]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]] [**Note:** The Outpatient Short Term Rehab copay [does not apply to services provided as part of a Home Health Care visit] [applies, regardless of place of service, including the home].]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Includes: [Cardiac Rehab] Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy [Chiropractic Therapy (includes Chiropractors)]]	
[**Outpatient Short-Term Rehabilitative Therapy**	
• **Outpatient Physical Therapy** [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
• **Outpatient Speech, Hearing and Occupational Therapy** [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited]	[No charge after the $[0-150] Specialist per visit copay; No charge after the Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
[**Outpatient Cardiac Rehabilitation** [Contract] [Calendar] Year Maximum: [36-Unlimited] days	[No charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [[50-100]% [after plan deductible]]]
[[**Self-Referral**] **Chiropractic Care Services** [Contract] [Calendar] Year Maximum: [12-Unlimited] [visits] [days] [visits or days] [consecutive days per condition] [$[500-Unlimited]] Physician's Office Visit	 [No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay [but not less than $[20-150]]; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Home Health Care** [[Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary)]	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]]
[**Hospice** Inpatient Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Services (same coinsurance level as Home Health Care)	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[Lifetime Maximum: $[5,000-Unlimited]]	
Bereavement Counseling Services Provided as part of Hospice Care	
Inpatient	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[Services Provided by Mental Health Professional	Covered under Mental Health benefit]]
Maternity Care Services	
Initial Visit to Confirm Pregnancy [**Note:** OB/GYN providers will be considered [either] a [PCP or] Specialist [depending on how the provider contracts with CIGNA].	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	[No charge] [[50-100]% [after plan deductible]]
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Delivery - Facility (Inpatient Hospital, Birthing Center)	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Abortion Includes [elective and] non-elective procedures	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed and billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[**Family Planning Services**	
[Physician's Office Visit (tests, counseling)] [Office Visits, Lab and Radiology Tests and Counseling] [Maximum: subject to plan's Preventive Care dollar maximum] [**Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals):	

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Physician's Office Visits	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge] [[50-100]% [after plan deductible]]
[**Infertility Treatment** Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination Services Not Covered include: In-vitro, GIFT, ZIFT, etc. [Surgical Treatment: Limited to procedures for the correction of infertility.]	
Physician's Office Visit (Lab and Radiology Tests, Counseling)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
[Surgical Procedure Copay	[$[0-750] Surgical Copay [after plan deductible]] [[50-100]% [after plan deductible]]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[Lifetime Maximum: $[5,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]]	
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.	

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Physician's Office Visit (Lab and Radiology Tests, Counseling)	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
Lifetime Maximum: $[10,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]	
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[100% at Lifesource center after $[0-4,500] per admission [copay] [deductible], otherwise [50-100]% after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [[50-100]% after $[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [100% at Lifesource center [after plan deductible], otherwise [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]] [100% at Lifesource center [after plan deductible], otherwise [50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Lifetime Travel Maximum: $[10,000-Unlimited] per transplant	No charge (only available when using Lifesource facility)]
[**Durable Medical Equipment (including External Prosthetic Appliances)** [[Contract] [Calendar] Year Maximum: [$500-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [**Note:** Services do accumulate to the plan's out-of-pocket maximum.]	[50-100]% [after plan deductible]]
[**Durable Medical Equipment** [[Contract] [Calendar] Year Maximum: $[700-Unlimited]] [**Note:** Services do accumulate to the plan's Lifetime maximum.]	[No charge [after plan deductible]] [50-100]% [after plan deductible]]]
[**External Prosthetic Appliances** [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [**Note:** [The EPA deductible will not accumulate to the plan Out-of-Pocket maximum.] Services do accumulate to the plan's Lifetime maximum.]	[No charge [after $[0-500] EPA deductible per [Contract] [Calendar] Year]] [$[0-500] EPA deductible per [Contract] [Calendar] Year, then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]]
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[**TMJ Surgical and Non-surgical** Always excludes appliances and orthodontic treatment. Subject to medical necessity.	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
[**Surgical and**] **Non surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]	

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Obesity/Bariatric Surgery** **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.	
Physician's Office Visit	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]
Inpatient Facility	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient Facility	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Physician's Services	[No charge [after plan deductible]] [[50-100]% [after plan deductible]]
Lifetime Maximum: $[8,000-Unlimited] Coinsurance charges for obesity surgery will not accumulate to the plan Out-of-Pocket maximum.]	
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[No charge after the $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]]
[**Routine Foot Disorders**	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.]
[**Routine Foot Disorders**	
Physician's Office Visit [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only X-ray and/or lab services performed or billed] [[50-100]% [after plan deductible]]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]	
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]	
[**Mental Health**	[Not Covered]
Inpatient	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
[Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility [copay] [deductible].]	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]]
[Outpatient ▪ Includes Individual, Group and Intensive Outpatient ▪ Applies to Physician's Office and Outpatient Facility]	[No charge after the $[0-150] per visit copay] [No charge [after plan deductible]] [$[0-150] per visit copay [after plan deductible]] [[50-100]% [after plan deductible]]
[[**Substance Abuse**] [**Chemical Dependency**]	[Not Covered]
Inpatient	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
[Outpatient (Includes Individual and Intensive Outpatient) Physician's Office Visit]	[No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay] [[50-100]% [after plan deductible]]
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility [copay] [deductible].]	[No charge after $[0-2,250] per visit [copay] [deductible] [and plan deductible]] [$[0-2,250] per visit [copay] [deductible], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]]
[Outpatient ▪ Includes Individual and Intensive Outpatient ▪ Applies to Physician's Office and Outpatient Facility]	[No charge after the $[0-150] per visit copay] [No charge [after plan deductible]] [$[0-150] per visit copay [after plan deductible]] [[50-100]% [after plan deductible]]
[**Mental Health**	[Not Covered]
Inpatient [Contract] [Calendar] Year Maximum: [8-Unlimited] days [Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1] [Residential for Substance Abuse: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient [Contract] [Calendar] Year Maximum: [20-Unlimited] visits	[No charge after $[0-150] per office visit copay] [Visits 1-20: No charge after $[0-150] per office visit copay Visits 20-[Unlimited]: No charge after $[0-150] per office visit copay] [[50-100]% [after plan deductible]]
Outpatient Group Therapy [(One group therapy session equals one individual therapy session)] [[Contract] [Calendar] Year Maximum: [40-Unlimited] visits]	[No charge after $[0-100] per visit copay] [[50-100]% [after plan deductible]]

BENEFIT HIGHLIGHTS	[IN-NETWORK]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Based on a ratio of 1:1	[[50-100]% after $[0-2,500] per program [copay] [deductible] [[50-100]% [after plan deductible]]]
[[**Substance Abuse**] [**Chemical Dependency**]	[Not Covered]
Inpatient [Contract] [Calendar] Year Maximum: [8-Unlimited] days [Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1] [Residential for Substance Abuse: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[No charge after $[0-4,500] per admission [copay] [deductible] [and plan deductible]] [$[0-4,500] per admission [copay] [deductible], then [50-100]% [after plan deductible]] [$[0-1,500] per day [copay] [deductible] [up to [3-Unlimited] [copays] [deductibles] per admission], then [50-100]% [after plan deductible]] [[50-100]% [after plan deductible]]
Outpatient [Contract] [Calendar] Year Maximum: [20-Unlimited] visits	[No charge after $[0-150] per office visit copay] [Visits 1-20: No charge after $[0-150] per office visit copay Visits 20-[Unlimited]: No charge after $[0-150] per office visit copay] [[50-100]% [after plan deductible]]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Maximum: Each visit provided as part of a program accumulates to the Outpatient Substance Abuse benefit maximum on a 1:1 ratio basis with Outpatient Substance Abuse visits.	[[50-100]% after $[0-2,500] per program [copay] [deductible] [[50-100]% [after plan deductible]]]

Certification Requirements [- Out-of-Network]

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for [Mental Health or] Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred [will be reduced by 50% for Hospital charges] [will not include the first $[0-750] of Hospital charges] made for each separate admission to the Hospital unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below [will not include] [will be reduced by 50%]:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which CIGNA has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

[Outpatient Certification Requirements [Out-of-Network]

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CIGNA has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred [will be reduced by 50%] [will not include the first $[0-750]] for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred [will not include expenses incurred] [will be reduced by 50%] for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

[Advanced radiological imaging – CT Scans, MRI, MRA or PET scans]

[Hysterectomy]]

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- [inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- [outpatient facility services;]
- [intensive outpatient programs;]
- [advanced radiological imaging;]
- nonemergency ambulance; or
- transplant services.]

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CIGNA. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- [charges made for diagnosis and treatment of: (a) corns, calluses, weak or flat feet; (b) any fallen arches, chronic foot strain or instability or imbalance of the feet; (c) toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).]
- charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- [charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, [implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies [(tubal ligations, vasectomies, [elective abortions] and infertility testing.)]]
- [office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.]
- [charges made for Routine Preventive Care, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.]

- [charges made for Routine Preventive Care from age 3 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.]
- [charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child's life, including immunizations].
- charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- [charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.]
- [charges made for acupuncture/acupressure.]
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- [charges made for orthognathic surgery.]
- [On-line physician visits through an approved internet-based intermediary (dependent upon product and availability).]
- [charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage or oral contraceptives.]
- [charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically necessary.]
- charges for the treatment of newborn children for congenital defects, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia and, in the case of noncaucasian newborn infants, tests for sickle cell anemia. Coverage will also include routine nursery and pediatric care for well newborn children for the earlier of 5 days in a Hospital nursery, or until the mother is discharged from the Hospital.
- charges made for anesthesia, hospitalization services and/or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is: (a) under seven years of age and it is determined by two dentists that treatment in a hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; (b) a person with a serious diagnosed mental or physical condition; or (c) a person with a significant behavioral problem as determined by their physician.
- for a drug that has been prescribed for the treatment of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) the drug is recognized for the specific cancer treatment for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; or two articles from major peer-reviewed medical journals not contradicted by data in another article from such a journal; (b) the drug has been otherwise approved by the FDA; and (c) its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA for the use prescribed.
- charges for colorectal cancer examinations and laboratory tests for covered persons who: (a) are fifty years of age or older; (b) are less than fifty years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; or (c) are experiencing the following symptoms of colorectal cancer as determined by a physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests: (a) an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (b) a double-contrast barium enema every five years; or (c) a colonoscopy every ten years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 18 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance;
- appropriate immunizations, which are not subject to any copay, coinsurance, deductible, or dollar limit; and
- laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals up to a total of 20 visits for each Dependent child;
- services for which benefits are otherwise provided under this Comprehensive Medical Benefits section;
- services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Age Intervals are: Birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.

Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
  - the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
  - the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
  - the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
  - the trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - [Coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.]

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Diabetes

- charges made for Medically Necessary equipment, services and supplies when prescribed by a Physician and administered by a licensed health care professional, for the treatment of Type I, Type II and gestational diabetes. Coverage includes:
  - one self-management training program per lifetime per insured; and
  - additional training due to a significant change in symptoms or condition.

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and post-genetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of phenylketonuria (PKU). Coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Covered Expenses (Continued):

- [charges made for medical and surgical services [only at approved centers] for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.]

Covered Expenses (Continued)

- [orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.]

Covered Expenses (Continued)

- [Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.]

Covered Expenses (Continued)

Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if the Insurance Company has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. [Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations.] Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

Covered Expenses (Continued)

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

Covered Expenses (Continued)

Mental Health and [**Substance Abuse**] **Services**

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

[**Substance Abuse**] is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of [Substance Abuse].

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization [and Mental Health Residential Treatment Services.] **[Delete Without Mental Health Residential Treatment buy up]**

[Use for accounts subject to federal MH/SA parity.]

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

[Use only for accounts that are exempt from federal MH/SA parity.]

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

[Delete Without Mental Health Residential Treatment buy up]

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

[Use only for accounts that are exempt from federal MH/SA parity.]

Mental Health Residential Treatment services are exchanged with Inpatient Mental Health services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

[Delete Without Mental Health Residential Treatment buy up]

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling

nine or more hours in a week. [**Use only for accounts that are exempt from federal MH/SA parity**] Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

Inpatient [**Substance Abuse**] **Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient [Substance Abuse] Services include Partial Hospitalization sessions and Residential Treatment services.

[Use for accounts subject to federal MH/SA parity.]

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

[Use only for accounts that are exempt from federal MH/SA parity]

Inpatient [Substance Abuse] services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

[Substance Abuse] Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute [Substance Abuse] conditions.

[Use only for accounts that are exempt from federal MH/SA parity]

[Substance Abuse] Residential Treatment services are exchanged with Inpatient [Substance Abuse] services at a rate of two days of [Substance Abuse] Residential Treatment being equal to one day of Inpatient [Substance Abuse] Treatment.

[Substance Abuse] Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of [Substance Abuse]; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting;

and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a [Substance Abuse] Residential Treatment Center when she/he is a registered bed patient in a [Substance Abuse] Residential Treatment Center upon the recommendation of a Physician.

Outpatient [Substance Abuse] Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a

Hospital, including outpatient rehabilitation in an individual,[a group], or a [Substance Abuse] Intensive Outpatient Therapy Program.

Outpatient [Substance Abuse] Rehabilitation Services

A [Substance Abuse] Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed [Substance Abuse] program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

[Use only for accounts that are exempt from federal MH/SA parity]

[Substance Abuse] Intensive Outpatient Therapy Program services are exchanged with Outpatient [Substance Abuse] services at a rate of one visit of [Substance Abuse] Intensive Outpatient Therapy being equal to one visit of Outpatient [Substance Abuse] Rehabilitation Services.

[Substance Abuse] Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. the Insurance Company will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and [Substance Abuse] Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.

[Add exclusion when Mental Health Residential Treatment buy up is selected remove exclusion]

- Mental Health Residential Treatment.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Covered Expenses (Continued)

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Insurance Company for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

Covered Expenses (continued)

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. [Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.]

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  a. rigid and semirigid custom fabricated orthoses,
  b. semirigid prefabricated and flexible orthoses; and
  c. rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  a. for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  b. when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  c. when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  d. for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  a. no more than once every 24 months for persons 19 years of age and older and
  b. no more than once every 12 months for persons 18 years of age and under.
  c. replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Covered Expenses (Continued)

Infertility Services [OPTION I]

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluations.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

Covered Expenses (Continued)

Infertility Services [OPTION II]

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

Covered Expenses (Continued)

Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, [cardiac rehabilitation] and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acuteneuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- [To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.]
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions [without evidence of an underlying medical condition or neurological disorder];
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, [or] verbal apraxia [or swallowing dysfunction] that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status;

The following are specifically excluded from Chiropractic Care Services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Vitamin therapy.

[If multiple outpatient services are provided on the same day they constitute one visit.]

[A separate Copayment will apply to the services provided by each provider.]

Covered Expenses (Continued)

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, [cardiac rehabilitation]and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-term Rehabilitative Therapy:

- [To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.]
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions [without evidence of an underlying medical condition or neurological disorder];
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, [or] verbal apraxia [or swallowing dysfunction] that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status
- [Multiple [outpatient] services provided on the same day constitute one visit, but a separate Copayment will apply to the services provided by each Physician.;]

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Covered Expenses (Continued)

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

[You do not need a referral from your Primary Care Physician.]

The following limitation[s]s [apply][applies] to Chiropractic Care Services:

- [To be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness].
- [Services are not covered if they are considered custodial, training, developmental or educational in nature].
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Vitamin therapy;
- [Massage therapy in the absence of other modalities].

Covered Expenses (Continued)

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Covered Expenses (Continued)

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures [at designated facilities throughout the United States or its territories.] This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

[Add with PPO, EPO, OAP]

[All Transplant services, other than cornea, are covered at 100% when received at CIGNA LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with CIGNA for those Transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with CIGNA for Transplant services, are] [not covered.] [covered at the Out-of-Network level.]

[All Transplant services, other than cornea, must be received at a CIGNA LIFESOURCE Transplant Network® facility. Cornea transplants are payable when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities. Transplant services received at any other facilities are not covered.]

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

Covered Expenses (Continued)

[**Prescription Drug Benefits**

- charges made for Prescription Drugs, subject to the Deductibles, Coinsurance and Limits shown in the Medical Schedule, except that the following Prescription Drugs, by way of example, but not of limitation are excluded:
    - drugs or medications available over the counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication;
    - any drugs that are labeled as experimental or investigational;
    - Food and Drug (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    - prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
    - prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
    - diet pills or appetite suppressants (anorectics);
    - prescription smoking cessation products; or
    - any non-Prescription drugs.]

SUPPLEMENTAL MEDICAL BENEFITS

If you [or any one of your Dependents], while insured for Supplemental Medical Benefits, incurs Covered Expenses as defined below, CG will pay 100% of the amount of Covered Expenses so incurred. The amount of Supplemental Medical Benefits payable will be subject to the Maximum Benefit Provision.

Maximum Benefit Provision

The total amount of Supplemental Medical Benefits payable for all expenses incurred for you and your Dependents, if any, in a calendar year will not exceed $[3,000-10,000] [per family,] per calendar year.

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for the charges below. Expenses are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician. Covered Expenses will include only those expenses incurred for charges made:

- for medical services and supplies to the extent that no benefits are payable under your Employer's medical insurance plan solely because of: (a) Coinsurance factors or Deductibles; (b) dollar limits; or (c) limits on the number of days for which benefits are payable.
- [for or in connection with cosmetic surgery when: (a) a person receives an Injury which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry; (c) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (d) it is performed to correct a congenital abnormality on one of your Dependents who has not reached skeletal maturity.
- for eye examinations and eyeglasses, including contact lenses.
- for hearing examinations and hearing aids.
- for routine physical examinations and immunizations.
- for dental services and supplies provided by a Dentist to the extent that no benefits are payable under your Employer's dental plan solely because of: (a) Coinsurance factors or Deductibles; or (b) dollar limits.
- for orthodontia.
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including

but not limited to, the removal of calluses and corns or the trimming of toenails.]

- [for any expense considered as a medical expense under Internal Revenue Code section 213, except as specifically excluded. See **General Limitations.**]

Limitations

No payment will be made for expenses incurred to the extent that you [or your Dependents] are entitled to receive payment for such expenses under any other Group Health Plan sponsored by your Employer.

See the section in this certificate entitled **General Limitations** for additional restrictions that apply to these benefits.

Extension Of Supplemental Medical Benefits

Covered Expenses incurred after a person's Supplemental Medical Benefits cease, but within one year, will be deemed to be incurred while he is insured if such expense is for an Injury or a Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred. This Extension of Supplemental Medical Benefits will not apply to a child born as a result of a pregnancy which exists when these benefits cease.

General

There is no Conversion Privilege applicable to Supplemental Medical Benefits once insurance under the Policy ceases.

MEDICAL CONVERSION PRIVILEGE

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by CIGNA only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CIGNA within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- [your insurance did not cease because the policy in its entirety canceled.]

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

[**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: (a) is not eligible for Medicare; (b) would not be Overinsured, (c) has paid all required premium or contribution, (d) has not performed an act or practice that constitutes fraud in connection with the coverage, and (e) has not made an intentional misrepresentation of a material fact under the terms of the coverage.]

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CIGNA's underwriting standards for individual policies.
- Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an

insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CIGNA's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). CIGNA or the Policyholder will give you, on request, further details of the Converted Policy.

MEDICAL CONVERSION PRIVILEGE

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by CIGNA only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CIGNA within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- ~~you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.~~
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- [your insurance did not cease because the policy in its entirety canceled.]

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

[**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: (a) is not eligible for Medicare; (b) would not be Overinsured, (c) has paid all required premium or contribution, (d) has not performed an act or practice that constitutes fraud in connection with the coverage, and (e) has not made an intentional misrepresentation of a material fact under the terms of the coverage.]

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CIGNA's underwriting standards for individual policies.

- Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CIGNA's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). CIGNA or the Policyholder will give you, on request, further details of the Converted Policy.

Prescription Drug Benefits
The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule.

To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Add text when Network Retail Pharmacies provide an increased supply limit

[Certain retail Participating Pharmacies can fill your prescription [excluding Specialty Medication] for an

[80-90][90-102]day supply [for an amount equal to 3x the retail Participating Pharmacy Copayment][at the same Copayment or Coinsurance that applies to the home delivery Participating Pharmacy Prescription Drugs][after you have filled a 30-day prescription for the same medication.].

Please [see our website at www.CIGNA.com][www.myCIGNAforhealth.com] [or] call the Member Services number on your ID card for a list of retail Participating Pharmacies that offer the [3x retail Participating Pharmacy Copayment level.].the home delivery Participating Pharmacy Copayment or Coinsurance level.]

Add text when member pays 100% of the discounted cost for non-preferred brand drugs, or drugs not covered under the plan.

[You and your Dependents will pay 100% of CIGNA's discounted cost at a Participating Pharmacy for:]

- [Brand-Name* drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List.]
- [Prescription Drugs and Related Supplies that are not Covered Expenses under this plan.]

Remove the Coinsurance paragraph for a copay only plan design.

[Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.]

[Charges

The term Charges means the amount charged by CIGNA to the plan when the Pharmacy is a Participating Pharmacy,[and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.]

Include the following for plans with Copayment feature.

[Copayments/

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.]

Use the following if an annual maximum is elected otherwise delete.

[Annual Maximum

The total amount of Prescription Drug benefits payable for all expenses incurred at a Pharmacy in a [contract][calendar] year will not exceed the Annual Maximums shown in The Schedule.]

Use the following when client elects pharmacy deductibles otherwise delete.

[[Contract][Calendar] Year Deductible]

Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies. These Deductibles are in addition to any Copayments or Coinsurance. Once the Deductible maximum shown in The Schedule has been reached you and your family need not satisfy any further Prescription Drug Deductible for the rest of that year.]

Include the following paragraph when client elects pharmacy out-of-pocket maximums otherwise delete.

[Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided by the benefit plan because of any:

[Coinsurance]

[Copayment]

[Deductible]

When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Use the following if lifetime maximum applies.		
[Lifetime Maximum-]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
Use the following box if an annual maximum is elected. Modify for client elect benefits. If no annual maximum is elected omit the box.		
[Annual Maximum] [Individual Annual Maximum]	 [$0-5,000 per person] [Not Applicable]	 [$0-,5000 per person] [Not Applicable]
[Family Annual Maximum]	[$0-15,000 per family] [Not Applicable]	[$0-15,000 per family] [Not Applicable]
Always use the following when client elects pharmacy deductibles that are NOT combined with medical or Collective. Modify for client elect benefits. If no deductible is elected omit the box.		
[[Contract][Calendar] Year Deductible]* [Individual]	[$0-700 per person] [Not Applicable]	[$0-700 per person] [Not Applicable]
[Family]	[$0-2,100per family] [Not Applicable]	[$0-2,100per family] [Not Applicable]
Use the following box for "Collective" family deductible. Otherwise delete.		
[[Contract] [Calendar] Year Deductible]* [Individual]	 [Not Applicable]	 [Not Applicable]
[Family]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
Use the following box if combined MED/PHARM deductible Otherwise delete.		
[[Contract][Calendar] Year Deductible]* [Individual]	 [Refer to the Medical Benefits Schedule]	 [Refer to the Medical Benefits Schedule]
[Family]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY

Deductible Option 1- The following language will only be included if the group has elected to waive the deductible for retail or home delivery.

[*Does not apply to prescriptions filled at a [retail] [or][home delivery] [Participating] Pharmacy.] [Copayments and Coinsurance for [retail] [or] [home delivery] [Participating] Pharmacy drugs [do not] apply toward the Deductible.]

Deductible Option 2- The following language will only be included if the group has elected to waive the deductible for the following medications.

[* Preventive Medications

Prescription medications used to prevent any of the following medical conditions are not subject to the Deductible. However, this does not include any drugs or medications used to treat an existing illness, injury or condition.] [Any Copayments/ Coinsurance which have been paid by a person for these medications [do not] apply toward the Deductible:]

- [hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke and prenatal nutrient deficiency]

Option 2+- Include if additional medications are elected by the group

[nutrient deficiency;]

[smoking cessation;]

[antiobesity and weight loss.]

Deductible Option 3- Include the following if elected by the group.

[*The following classes of drugs are not subject to the Deductible.] [Any Copayments/Coinsurance which have been paid by a person for these classes of drugs [do not] apply toward the Deductible:]

[generic drugs;]

[brand drugs;]

[preferred brand drugs;]

[non-preferred brand drugs;]

[certain Specialty Medications as listed in the "Definitions" section].

[diabetic drugs and Related Supplies;]

Use the following when pharmacy out-of-pocket maximums are elected but NOT combined with medical or Collective. Modify for client elect benefits. If an OOP maximum is not elected delete the box.

[Out-of-Pocket Maximum] [Individual]	[$0-10,000 per person] [Not Applicable]	[$0-10,000 per person] [Not Applicable]
[Family]	[$0-30,000 per family] [Not Applicable]	[$0-30,000 per family] [Not Applicable]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Use the following box for "Collective" family OOP Otherwise delete. .		
[Out-of-Pocket Maximum] [Individual]	[Not Applicable]	[Not Applicable]
[Family]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
Use the following box for combined MED/PHARM OOP. Otherwise delete.		
[Out-of-Pocket Maximum] [Individual]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]
[Family]	[Refer to the Medical Benefits Schedule]	[Refer to the Medical Benefits Schedule]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

1 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
	The amount you pay for each 30-day supply	**The amount you pay for each 30-day supply**
1 Tier **Retail Prescription Drugs****	*Use for copay plans* [No charge after $0-$30] *Use for coinsurance plans* [0-50 after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $ 0-$30 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-$30] [and] [a maximum of $0-$30,] then the plan pays 100% after plan deductible] *Use for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Incentive home delivery* [plus [$1 - $30 or 1% - 50%] not to exceed CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication.]	*Modify based on account specifics* [0- 70% after plan deductible]
[**Specialty Medications are covered through home delivery only]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

1 Tier Home Delivery Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
	The amount you pay for each 90-day supply	**The amount you pay for each 90-day supply**
1 Tier **[Home Delivery Prescription Drugs]**	*Use for copay plans* [No charge after $0-$90] *Use for coinsurance plans* [0-50% after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 or $ 0-90 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-90][and][a maximum of $0-90,] then the plan pays 100% after plan deductible]	*Modify based on account specifics*

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

2 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
2 Tier **Retail Prescription Drugs****	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Generic *	*Use for copay plans* [No charge after $0-30] *Use for coinsurance plans* [0-50% after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $0-30 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-30] [and] [a maximum of $0-30,] then the plan pays 100% after plan deductible] *Use for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *(Add for Incentive home delivery)* [plus [$1 - $30 or 1% - 50%] not to exceed CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication.]	*Modify based on account specifics* [0-70% after plan deductible]

* Designated as per generally-accepted industry sources and adopted by CIGNA
[**Specialty Medications are covered through home delivery only]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

2 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Brand-Name *	*Use for copay only plan* [No charge after $0-90] *Use for coinsurance* [0-50% after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $0-90 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-90] [and] [a maximum of $0-90,] then the plan pays 100% after plan deductible] *Add for Incentive home delivery* [plus [$1 - $50 or 1% - 50%] not to exceed CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication.] *Add for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication]	*Modify based on account specifics* [0-70% after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

2 Tier Home Delivery Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
2 Tier **[Home Delivery Prescription Drugs]**	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Generic *	*Use for copay plans* [No charge after $0-90] *Use for coinsurance plans* [0-50% after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $ 0-90 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-90][and][a maximum of $0-90,] then the plan pays 100% after plan deductible]	*Modify based on account specifics* [0-70% after plan deductible]
Brand-Name *	*Use for copay plans* [No charge after $0- $270] *Use for coinsurance plans* [0-50 after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $0- $270, then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to[a minimum of $0- $270][and][a maximum of $0- $270,] then the plan pays 100% after plan deductible]	*Modify based on account specifics* [0-70% after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
3 tier **[Retail Prescription Drugs**]**	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Tier 1-standard **[Generic* drugs on the Prescription Drug List]** ***OR*** *Tier 1-Advantage L* **[Generic*Drugs designated as Preventive Medication on the Prescription Drug List]** **OR** *Tier 1-Performance L* **[Generic*Drugs designated as Preventive Medication on the Prescription Drug List]**	*Use for copay plans* [No charge after $0-30] *Use for coinsurance plans*] [0-50 % after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $ 0-30 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-30][and][a maximum of $0-30,] then the plan pays 100% after plan deductible] *Add for Incentive home delivery Drug.* [plus [$1 - $30 or 1% - 50%] not to exceed CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication.] *Add for Mandatory home delivery.* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Retail Lock-out* [100% of CIGNA's discounted cost after the first fill of Specialty Medication]	*Modify based on account specifics* [0-70% after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA [**Specialty Medications are covered through home delivery only]		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 2-Standard **[Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]** **Or** *Tier 2-Advantage L* **[Generic Drugs that are not designated as Preventive Medication on the Prescription Drug List]** ***OR*** *Tier 2-Performance L* **[Generic Drugs not designated as Preventive Medication on the Prescription Drug List and Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	*Use for copay plans* [No charge after $0-60] *Use for coinsurance plans* [0-50 after plan deductible] *Use for "Greater of" plans* [The greater of [0-50% or $ 0-60 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0-60][and] [a maximum of $0-60,]then the plan pays 100% after plan deductible] *Add for Incentive home delivery* plus [$1 - $60 or 1% - 50%] not to exceed CIGNA's discounted cost, for refills beyond [1-5] for Maintenance Medication.] *Add for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Retail Lock-out* [100% of CIGNA's discounted cost after the first fill of Specialty Medication]	*Modify based on account specifics* [0-70% after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 3- Standard **[Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]** **OR** *Tier 3- Advantage L* **[Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]** **OR** *Tier 3- Performance L* **[Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]**	*Use for copay plans* [No charge after $0- $120] *Use for coinsurance plans* [0-70 % after plan deductible] *Use for "Greater of" plans* [The greater of [0-70 % or $ 0- $120 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-70% subject to [a minimum of $0- $120] [and][a maximum of $0- $120 ,] then the plan pays 100% after plan deductible] *Add for Incentive home delivery* plus [$1 - $120 or 1% - 70%] not to exceed CIGNA's discounted cost, for refills beyond [1-5] for Maintenance Medication.] *Add for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Retail Lock-out* [100% of CIGNA's discounted cost after the first fill of Specialty Medication]	*Modify based on account specifics* [0-70% after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

4th Tier Retail Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
[Tier 4] *Use the following for Self-Administered Injectable Drugs:* [**Self-Administered Injectable Drugs** (e.g. injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma)] *Use the following for Therapeutic Drugs:* [**Drugs in the following Therapeutic Class:]** • [Oral Contraceptive drugs and prescription appliances for contraception] • [Drugs for the treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido] • [Antihistamines] • [Expectorants, Cough & Cold drugs] *Use the following for Specialty Medication:* **[Specialty Medication]**	*Use for copay plans* [No charge after $0-130] *Use for coinsurance plans* [0-[90 % after plan deductible] *Use for "Greater of" plans* [The greater of 0-90 % or $ 0-130 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-90% subject to [a minimum of $0-130] [and] [a maximum of $0-170,] then the plan pays 100% after plan deductible] *Use for Incentive home delivery* [plus [$1-$130 or 1%-90%] not to exceed CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Mandatory home delivery* [100% of CIGNA's discounted cost for refills beyond [1-5] for Maintenance Medication] *Use for Retail Lock-out* [100% of CIGNA's discounted cost after the first fill of Specialty Medication]	*Modify based on account specifics* [0-90 % after plan deductible]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 Tier Home Delivery Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
[Home Delivery Prescription Drugs]	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Tier 1-standard **[Generic* drugs on the Prescription Drug List]** ***OR*** *Tier 1-Advantage L* **[Generic*Drugs designated as Preventive Medication on the Prescription Drug List]** **OR** *Tier 1-Performance L* **[Generic*Drugs designated as Preventive Medication on the Prescription Drug List]**	*Use with 30 day supply for Specialty Medications* [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] *Use for copay plans* [No charge after $0- $90] *Use for coinsurance plans* [0-50 % after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $ 0- $90 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to [a minimum of $0- $90] [and] [a maximum of $0- $90,] then the plan pays 100% after plan deductible]	*Modify based on account specifics* [0-90 % after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 Tier Home Delivery Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 2-Standard **[Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]** **Or** *Tier 2-Advantage L* **[Generic Drugs that are not designated as Preventive Medication on the Prescription Drug List]** ***OR*** *Tier 2-Performance L* **[Generic Drugs not designated as Preventive Medication on the Prescription Drug List and Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]**	*Use with 30 day supply for Specialty Medications* [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] *Use for copay plans* [No charge after $180] *Use for coinsurance plans* [0-50 % after plan deductible] *Use for "Greater of" plans* [The greater of 0-50 % or $ 180 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-50% subject to a minimum of $180 and a maximum of $180, then the plan pays 100% after plan deductible]	*Modify based on account specifics* [0-90 % after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

3 **Tier Home Delivery Schedule**

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 3- Standard **[Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]** **OR** *Tier 3- Advantage L* **[Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent]** **OR** *Tier 3- Performance L* **[Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List]**	*Use with 30 day supply for Specialty Medications* [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.] *Use for copay plans* [No charge after $360] *Use for coinsurance plans* [0-70 % after plan deductible] *Use for "Greater of" plans* [The greater of 0-70 % or $ 360, then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-70%, subject to a minimum of $360 and a maximum of $360, then the plan pays 100% after plan deductible]	*Modify based on account specifics* [0-90 % after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

4th Tier Home Delivery Schedule

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
[Tier 4] *Use the following for Self-Administered Injectable Drugs*: **[Self-Administered Injectable Drugs** (e.g. injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma)] *Use the following for Therapeutic Drugs:* **[Drugs in the following Therapeutic Class]** • [Oral Contraceptive drugs and prescription appliances for contraception] • [Drugs for the treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido] • [Antihistamines] • [Expectorants, Cough & Cold drugs] *Use the following for Specialty Medication:* **[Specialty Medication]**	*Use for copay plans* [No charge after $400] *Use for coinsurance plans* [0-90% after plan deductible] *Use for "Greater of" plans* [The greater of 0-90% or $400 then the plan pays 100%] *Use for coinsurance plans with a minimum and/or maximum* [0-90% subject to [a minimum of $400] [and] [a maximum of $510,] then the plan pays 100% after plan deductible] *Use with 30 day supply for Specialty Medication* [Specialty Medications are limited to a 30-day supply and are subject to the same Copayment or Coinsurance that applies to retail Participating Pharmacies.]	*Modify based on account specifics* [0-90 % after plan deductible]
* Designated as per generally-accepted industry sources and adopted by CIGNA		

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Include text below for flat coinsurance plans.		
[Retail Prescription Drugs]	[0-50 %]	[0-70 %]
[Home Delivery Drugs]	[0-50 %]	[0-70 %]

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

PRESCRIPTION DRUG BENEFITS

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CIGNA will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CIGNA, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

Include text that follows for plans without a 365 day supply limit.

Remove "Participating" when coverage for retail non-Participating Pharmacies is elected or is a state requirement and add appropriate number for day supply. Add exclusion for Specialty medications if Specialty Medications are limited to home delivery only.

- [up to a consecutive [30-102]day supply, [excluding Specialty Medications,] at a retail [Participating] Pharmacy unless limited by the drug manufacturer's packaging: or]

Add text if home delivery pharmacy coverage is included. Remove "Participating" when coverage for home delivery non-Participating Pharmacies is elected or is a state requirement. If Specialty Medication is not available in a [90-102] day supply, add text in the first bullet and add the 2nd bullet with the 30-day supply limit text.

- [up to a consecutive [90-102]day supply [excluding Specialty Medications] at a home delivery [Participating] Pharmacy, unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive 30-day supply for Specialty Medications at a home delivery Participating Pharmacy unless limited by the drug manufacturer's packaging; or.]

Add next bullet if plan includes the retail lock-out benefit.

- [to one fill of Specialty Medication at a retail Participating Pharmacy. If you exceed the one fill allowed at a retail Participating Pharmacy, you will be required to pay 100% of CIGNA's discounted cost.]
- [to a dosage and/or dispensing limit as determined by the P&T Committee;]

Add if plan includes the mandatory home delivery benefit.

- [up to [1-5] refills for Maintenance Medications at a retail Participating Pharmacy. If you exceed the number of refills allowed at a retail Participating Pharmacy, you will be required to pay 100% of CIGNA's discounted cost.]

Add if plan includes the incentive home delivery benefit.

- [up to [1-5] refills for Maintenance Medications at a retail Participating Pharmacy. If you exceed the number of refills allowed at a retail Participating Pharmacy, you will be required to pay the applicable Copayment plus an additional amount. The applicable Copayments are identified in the Prescription Drug Schedule.]

PRESCRIPTION DRUG BENEFITS

Include text that follows for plans with a 365 day supply limit.

If Specialty Medication is not available in a 365 day supply, add text in the first bullet. Remove "Participating" in second bullet when retail or home delivery non-Participating Pharmacies coverage is elected or is a state requirement.

- [up to a consecutive 365-day supply,[excluding Specialty Medications] at a Pharmacy unless limited by the drug manufacturer's packaging: or]
- [up to a consecutive [30-102] day supply for Specialty Medications at a retail [Participating]Pharmacy or a[90-102] day supply at a home delivery [Participating] Pharmacy unless limited by the drug manufacturer's packaging; or.]
- [to a dosage and/or dispensing limit as determined by the P&T Committee;]

PRESCRIPTION DRUG BENEFITS

Limitations (Continued)

Include text for closed formulary plans.

[Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.]

Include text for Mandatory Generic plans.

[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that you or your Physician insists on: (a) a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the required Copayment identified in the Schedule;] [or (b) a non- Prescription Drug List drug. You will be financially responsible for the full cost of the non-Prescription Drug List drug.] *use (b) for closed formulary plans.*

Include text for Dispense as Written.

[In the event that you insist on: (a) a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the required Copayment identified in the Schedule;] [or (b) a non-Prescription Drug List drug. You will be financially responsible for the full cost of the non-Prescription Drug List drug.] *use (b) for closed formulary plans.*

Remove prior authorization text for plans that do not require prior authorization.

[Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. *(remove text if step therapy is not included in policyholder plan design)[*Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.] If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CIGNA to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.]

Include 6-month review text with 3 and 4 tier plans.

[All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

Limitations (Continued)

Include 6- month exclusion text with 3 and 4 tier plans.

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such sixth month period, all newly approved FDA drugs will be designated as either non-Preferred or non-Prescription Drug List drugs for the first sixth months of coverage until the P& T Committee evaluates the Prescription Drug clinically for a different designation.]

Include 6-month review text with 1 & 2 tier plans.

[All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

Include 6- month exclusion text with 1 & 2 tier plans.

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.]

PRESCRIPTION DRUG BENEFITS

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

Add text below for plans with a copay

[When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

PRESCRIPTION DRUG BENEFITS

Exclusions

No payment will be made for the following expenses:

Remove this standard exclusion for accounts that elect to add the Rx exclusion for Federal Legend drugs.

- [drugs available over the counter that do not require a prescription by federal or state law;]

Add exclusion for accounts that elect to add the Rx exclusion for Federal Legend drugs.

- [drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;]
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;

Include injectible text bullet that is applicable based on plan design.

- [injectable drugs, including injectable infertility drugs. However, self-administered injectables on the Prescription Drug List which are used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation are covered. However, upon prior authorization by CIGNA, injectable drugs may be covered subject to the required Copayment or Coinsurance.]
- [injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.]
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, [The American Medical Association Drug Evaluations;] or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;

Delete text when contraceptives are covered.

- [contraceptive drugs, and prescription appliances for contraception;]

Delete text when oral fertility drugs are covered.

- [any fertility drug;]

Delete text when lifestyle drugs (drugs to treat erectile dysfunction) are covered.

- [drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;]

Delete text when prescription vitamins are covered.

- [prescription vitamins (other than prenatal vitamins), pediatric multivitamins containing flouride, and dietary supplements]

Delete text when dental prescription products are covered.

- [prescription dental products (prescription fluoride products and prescription periodontal care products such as mouthwashes and other oral therapy)]

Delete text when growth hormones are covered.

- [human growth hormones;]

Delete text when anabolic steroids are covered.

- [anabolic steroids;]

PRESCRIPTION DRUG BENEFITS
Exclusions

Delete text when non-preferred brand-name drugs are covered.

- [Brand-Name* drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List;]

Delete text when pre-filled insulin pens and cartridges are covered.

- [pre-filled insulin pens and cartridges;**]**

Delete text when diet drugs are covered.

- [diet pills or appetite suppressants (anorectics);]

Delete text when smoking cessation products are covered.

- [prescription smoking cessation products;]
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Remove text for prescription drug standalone plans.

- [any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;]

[Other limitations are shown in the Medical “Exclusions” section of your certificate;]

Include any of the exclusions below that are applicable for prescription drug standalone plans.

- [expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

- the subject of review or approval by an Institutional Review Board for the proposed use; or
- the subject of an ongoing phase I, II or III clinical trial.
- Prescription Drugs for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Prescription Drugs when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- for charges which would not have been made if the person had no insurance.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- prescription drug costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared, or undeclared, riot or insurrection.
- Any unproven or investigational services and supplies, including all related services and supplies.

  Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, treatments, procedures, drugs and biologics or devices that are determined by CIGNA to be: Not demonstrated by the weight of existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the sickness, condition, injury or illness for which its use is proposed; or Not currently the subject of active investigation because prior investigations and/or studies failed to establish proven efficacy and/or safety; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use, except for accepted off-label use of drugs and biologics, consistent with CIGNA policy; or Substantially confined to use in the research setting; or The subject of review or approval by an Institutional Review Board for the proposed use, except as specifically provided in the "Clinical Trials" benefit section; or The subject of an ongoing phase I, II or III clinical trial, except as specifically provided in the "Clinical Trials" benefit section.

- Expenses incurred outside the United States, other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.]

PRESCRIPTION DRUG BENEFITS

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form [unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.] *include text for plans that only cover non-Participating Pharmacies for emergencies.*

Delete text if non-Participating Pharmacies are not covered.

[If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.]

Delete text if home delivery pharmacy coverage is not included.

[To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.]

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

Vision Benefits

[For You and Your Dependents]

Covered Expenses

[**Option 1**: The following language will be used if the description of Covered Benefits is included with the Vision Schedule.]

[The Schedule of Vision Benefits that accompanies your certificate booklet lists covered services.

CIGNA will pay for covered services incurred by you and your eligible Dependents subject to: frequency limits; benefit maximums; cost sharing provisions; and limitations as set forth in the Schedule of Vision Benefits.]

[**Option 2**: The following language will be included within the Certificate or as part of the Vision Schedule.]

[**Benefits Include**:]

[**Examinations** – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.] [or]

[**Examinations** – Vision Exam includes eye examination, with or without dilation, refraction and prescription. Contact lens professional services include fitting of lenses and follow-up care.] [or]

[**Vision Exam –** includes a comprehensive eye examination, with or without dilation, refraction and prescription for glasses.] [or]

[**Contact lens exam** – A complete examination, refraction, additional measurements, trial fitting, follow-up visit and prescription for contact lenses.]

[**Lenses (Glasses)** – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- [Polycarbonate lenses for children under 18 years of age;]
- [Oversize lenses;]
- [Rose #1 and #2 solid tints;]
- [20% savings on non-covered lens options;]
- [Progressive lenses covered up to bifocal lenses amount [with 20% savings on amount that exceeds frame allowance].]] [or]

[**Lenses (Glasses)** – Standard lenses of uncoated plastic or glass regardless of size or power subject to any Exclusions.]

[**Frames –** We will pay for new frames up to the retail value [or benefit maximum] shown in the Schedule of Benefits.] [or]

[**Frames** – One frame - choice of frame covered up to retail plan allowance[, plus a 20% savings on amount that exceeds frame allowance].]

[[**Contact Lenses** – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.]

[Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens benefit shown on the Schedule of Benefits.]] [or]

[**Contact Lenses** – Contact lenses are covered in lieu of lenses and frame benefits. Contact lenses are payable in accordance with the benefit maximums shown in the Schedule of benefits. Coverage for therapeutic contact lenses will be provided, as determined and documented by your Vision Provider; (1) when your visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; or (2) in certain cases of anisometropia, keratoconus, or aphakis. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to minus or plus correction will be covered in accordance with the elective contact lens benefit shown in the Schedule of Benefits.]

[**Note**: Benefits are payable up to the retail value [or benefit maximum] shown in the Schedule.]

[**Low Vision** -term that means partial sight or when sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid these patients with their specific needs.]

[**Safety Eyewear** - provides prescription lenses [Necessary corrective lenses [single vision, bifocal, trifocal][or other more complex lenses] covered in full; Minimum prescription of +/- .50 diopter required] and frames[top or side shield as specified by certain industry standards] OSHA certified as safe for a work environment by meeting necessary ANSI standards and test requirements [OSHA 29 CFR 1910.132 (for PPE) and OSHA 29 CFR 1910.133 for Eye and Face Protection.]

[Vision Benefits]

[For You and Your Dependents]

[Expenses Not Covered]

[Covered Expenses will not include, and no payment will be made for:

- [Orthoptic or vision training and any associated supplemental testing.]
- [Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.]
- [Two pair of glasses, in lieu of bifocals or trifocals.]
- [Prescription sunglasses.]
- [Medical or surgical treatment of the eyes.]
- [Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.]
- [Magnification or low vision aids.]
- [Any non-prescription eyeglasses, lenses, or contact lenses.]
- [Safety glasses or lenses required for employment.]
- [VDT (video display terminal)/computer eyeglass benefit.]
- [Charges in excess of the Maximum Reimbursable Charge for the Service or Materials.]
- [Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.]
- [Experimental or non-conventional treatment or device.]
- [High Index lenses of any material type.]
- [Lens treatments or “add-ons”, except rose tints (#1 & #2), and oversize lenses.]
- [For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.]
- [Any injury or illness when paid or payable by Workers’ Compensation or similar law, or which is work-related.]
- [Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.]

[Other Limitations are shown in the "Exclusions/General Limitations" section.]]

[or]

[Expenses Not Covered]

[Covered Expenses will not include, and no payment will be made for:

- [Orthoptic or vision training and any associated supplemental testing.]
- [Plano lenses.]
- [Lens Coatings.]
- [Two pair of glasses, in lieu of bifocals or trifocals.]
- [Prescription sunglasses.]
- [Medical or surgical treatment of the eyes.]
- [Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.]

- [Photochromatic lenses.]
- [Magnification or low vision aids.]
- [Any non-prescription eyeglasses, lenses, or contact lenses.]
- [Safety glasses or lenses required for employment.]
- [VDT (video display terminal) benefit.]
- [Charges in excess of the Maximum Reimbursable Charge for the Service or Materials.]
- [Charges incurred after the Policy ends or the Insured's coverage under the Policy ends.]
- [Experimental or non-conventional treatment or device.]
- [High Index lenses of any material type.]
- [Lens treatments or “add-ons”, except solid tints (#1 & #2), and oversize lenses.]
- [For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.]

[Other Limitations are shown in the "Exclusions/General Limitations" section.]]

Vision Benefits

[For You and Your Dependents]

[Covered Expenses]

[If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for charges made [In-Network] for one complete eye exam, including basic vision screening, refraction and tonometric testing, CIGNA will pay that portion of the expense remaining after you or your Dependent has paid the required Copayment shown in The Schedule. You do not need a referral from your PCP to access these services.]

[Expenses incurred for charges made [In-Network] for the purchase of eyeglasses and contact lenses will be subject to the maximum benefit shown in The Schedule.]

[Exclusions]

[The following are specifically excluded from coverage;]

- [any services or items related to orthoptics or vision training;]
- [magnification vision aids;]
- [any nonprescription eyeglasses, lenses or contact lenses;]
- [any charges for tinting, antireflective coatings, prescription sunglasses or light-sensitive lenses;]
- [any eye examination required by an Employer as a condition of employment or which an Employer is required to provide under a collective bargaining agreement;]
- [any eye examination required by law;]
- [safety glasses or lenses required for employment;]
- [any eye examination or materials that exceed the frequency limits shown in The Schedule. Other limitations are shown in the "General Limitations" section.]]

[Vision Benefits]

[For You and Your Dependents]

[Covered Expenses]

[If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for:

- [an eye examination by an Optometrist or an Ophthalmologist;]
- [lenses to correct vision;]
- [eyeglass frames.]

[Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens benefit shown on the Schedule of Benefits.]

[CIGNA will pay you for such expenses up to the Maximum Payment shown in The Schedule.] [or] [Expenses incurred for charges made for the purchase of eyeglasses and contact lenses are subject to the benefit maximum shown in The Schedule.]

No payment will be made for more than one examination and one pair of lenses during a [12 or 24]-month period; or more than one pair of frames during a 24-month period for any one person.]

[[Limitations]

[No payment will be made for expenses incurred for:

- [medical or surgical treatment of the eye;]
- [lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;]
- [sunglasses, whether or not prescribed;]
- [replacement of lenses unless an examination shows that, using the existing prescription, a visual defect equal to at least one-half of one diopter in strength exists or a change of at least 10% in axis for astigmatism is required;]
- [care not listed in The Schedule;]
- [tinted lenses prescribed by the examiner when over Rose Tints No. 1 or No. 2; or]
- [charges for the excess cost of lenses over 65 millimeters in diameter.]

[Other Limitations are shown in the "General Limitations" sections.]

[In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the vision service if the benefits are provided for that service under:

- [this plan; and]
- [any medical expense plan or prepaid treatment program sponsored or made available by your Employer.]]

[[Expenses Not Covered]

[Covered Expenses will not include, and no payment will be made for:

- [Orthoptic or vision training and any associated supplemental testing.]
- [Medical or surgical treatment of the eyes.]
- [Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.]
- [Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.]
- [Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.]
- [Experimental or non-conventional treatment or device.]
- [Magnification or low vision aids.]
- [Any non-prescription eyeglasses, lenses, or contact lenses.]
- [Spectacle lens treatments, "add-ons", or lens coatings not shown as covered.]]
- [Prescription sunglasses.]
- [Two pair of glasses, in lieu of bifocals or trifocals.]
- [Safety glasses or lenses required for employment.]
- [VDT (video display terminal)/computer eyeglass benefit.]
- [Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.]]

[SCHEDULE [OR] VISION BENEFITS]

[CIGNA VISION] [or] [Vision Benefits]

[The Schedule] *[or]* [Schedule of Vision Benefits]
For Your and Your Dependents

[May insert Covered Expenses (form# HC-VIS1)]

[**Contract Year** – Contract Year means a twelve month period beginning on each MM/DD.]

[**Copayments** – Copayments are amounts to be paid by you [or] your Dependent for covered services.]

[**Low Vision** -term that means partial sight [or] when sight is not fully correctable with surgery, pharmaceuticals, contact lenses [or] glasses. There are various low vision aids, such as the bioptic telescope, which can aid these patients with their specific needs]

[[**Maximum Reimbursable Charge** (Vision) – The Maximum Reimbursable Charge (MRC) is the lesser of:

- The provider' normal charge; or
- The policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.] [or]

[Maximum Reimbursable Charge (MRC) – [Reasonable and Customary] charges for this plan are calculated based on the [50^{th} – 90^{th}] percentile of all charges in the geographic service area.] [or]

[REASONABLE AND CUSTOMARY CHARGE – [Reasonable and Customary] charges for this plan are calculated based on the 50^{th} – 90^{th}percentile of all charges in the geographic service area.]]

Benefit Highlights	**[In-Network Benefit]**	**[Out of Network Benefit]**
	[The Plan will pay 100%] [after any copayment,] [subject to any maximum shown below] [or] [You [or] Your Dependent Will Pay] [or] [This Plan Will Pay]]	[The Plan will reimburse you at 100%, [after any copayment,] subject to any maximum shown below.]
[Examinations] [Once every [12- 24]months] [Once every Calendar Year] [Once every other Calendar Year] [or] [One eye exam every [Calendar Year][Contract Year][12 consecutive months]] [One eye exam in any [2 Calendar Years][2 Contract Years][24 consecutive months]] [Eye Exam every [12 [or] 24] months]	[Covered in Full]; [or] [100%] [[after][$5 – $75] copayment [per office visit]]; [or] [[up to] [$20 - $250] [eye exam allowance]]; [or] [[after] [0%-50%]]	[[100%]; [[after] [$5 - $75] copayment]; [or] [[up to] [$12 – $250]] [or] [[after] [0%-50%]] [or] [In-Network coverage only]] [[60%-100%] of [R+C][MRC] [or] charges]

Benefit Highlights	[In-Network Benefit]	[Out of Network Benefit]
[Lenses and Frames [or] Contacts] [Once every [12- 24]months] [Once every Calendar Year] [Once every other Calendar Year] [Once every Plan Year]	[Covered in Full]; [or] [Not Covered]; [or] [100%] [up to [$80 -$999] [or] [after] [$5 – $200] copayment] [or] [after] [0%-50%]]	[100%] [up to [$80 – $999] [or] [In-Network coverage only]] [or] [[60%-100%] of [R+C][MRC] charges]
[Lenses and Frames]	[Covered in Full]; [or] [Not Covered]; [or] [100%] [up to [a total of] [$80 - $999] [toward Lenses, Frames [and Contact Lenses]] [or] [after] [$5 – $200] copayment] [or] [after] [0%-50%]]	[Not Covered]; [or] [100% up to a total of [$80 - $999] toward Lenses, Frames and Contact Lenses]]
[Eye Glasses/Contact Lenses[/Frames]]	[Not Covered]	[Not Covered]
[Lenses] [Once every [12 - 24]months] [Once every Calendar Year] [Once every other Calendar Year] [Once every Plan Year]] **[Lenses]** [Once every Plan Year] [One pair per [Calendar Year][Contract Year][12 consecutive months]] [One pair in any [2 Calendar Years][2 Contract Years][24 consecutive months]] [One pair per [12 [or] 24] month period]]	[Subject to the maximum shown above]	[Subject to the maximum shown above] [or] [In-Network coverage only]
[Single Vision [Lenses] [(pair)]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$20 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$12 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Bifocal [Lenses] [(pair)]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$18 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Trifocal [Lenses] [(pair)]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$40 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$24 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Lenticular [Lenses] [(pair)]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$50 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$ 30– $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Progressive [Lenses] [(pair)]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5– $75] copayment]; [or] [up to [$18 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]

Benefit Highlights	[In-Network Benefit]	[Out of Network Benefit]
[Contact Lenses] [One pair per [Calendar Year][Contract Year][12 consecutive months]] [One pair in any [2 Calendar Years][2 Contract Years][24 consecutive months]] [One pair per [12 [or] 24] month period]	[Subject to the maximum shown above]	[Subject to the maximum shown above] [or] [In-Network coverage only]
[Therapeutic] [Contact Lenses [in lieu of lenses and frame]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$18 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Elective] [Contact Lenses [in lieu of lenses and frame]]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5– $75] copayment]; [or] [up to [$18 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Medically Necessary Contacts]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999] [or] [after] [0%-50%]	[100%]; [or] [after [$5– $75] copayment]; [or] [up to [$12 – $999]] [or] [[60%-100%] of [R+C][MRC] charges]
[Ophthalmic Materials] [Frames [Once every [12 – 24]months] [Once every Calendar Year] [Once every other Calendar Year] [Once every Plan Year]] **[Frames]** [One pair per [Calendar Year][Contract Year][12 consecutive months]] [One pair in any [2 Calendar Years][2 Contract Years][24 consecutive months]] [One pair per [12 [or] 24] month period]	[Covered in Full]; [or] [100%] [or] [after] [$5 – $75] copayment]; [or] [up to [$30 - $999]; [or] [after] [0%-50%] [or] [Subject to the maximum shown above]	[100%]; [or] [after [$5 – $75] copayment]; [or] [up to [$18 – $999] [or] [Subject to the maximum shown above] [or] [In-Network coverage only] [or] [[60%-100%] of [R+C][MRC] charges]
[Low Vision] [Once every [12- 24]months] [Once every Calendar Year] [Once every other Calendar Year] [Once every Contract Year]	[100%] [up to [$500-$1,000]] [after] [0% - 30% coinsurance]	[100%] [up to [$500-$1,000] [after] [30% - 100% coinsurance]

[**Vision Network Savings Program:**]

[Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your CIGNA Vision Network Provider for details.]

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- **[**Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, [riot or insurrection].
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; [Surgical treatment of varicose veins;] Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; [Orthognathic Surgeries], Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions[, except as may be covered under the "Reconstructive Surgery" benefit].
- [surgical or nonsurgical] treatment of TMJ disorders [and craniofacial muscle disorders].
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. [However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when medically necessary.] Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are [also] covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including:

medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any [medications, drugs], services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- [Routine refractions,] eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.

- all noninjectable prescription drugs, [injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs,] nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- [If the Insured Person is eligible for Medicare Part A, B or D, CIGNA will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount CIGNA would have paid if it were the sole insurance carrier.]
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- massage therapy.
- for elective abortions.
- custodial care of a member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or inter-current health care needs. Custodial care includes any skilled or non skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of: walking, transferring or positioning in bed and range of motion exercises; self administered medications; meal preparation and feeding by utensil, tube or gastronomy; oral hygiene, skin and nail care, toilet use, routine enemas; nasal oxygen applications, dressing changes, maintenance of in-dwelling bladder catheters, general maintenance of colostomy ilieostomy, gastronomy, tracheostomy and casts.
- any unproven or investigational services and supplies, including all related services and supplies. Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, treatments, procedures, drugs and biologics or devices that are determined by CIGNA to be: Not demonstrated by the weight of existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the sickness, condition, injury or

illness for which its use is proposed; or Not currently the subject of active investigation because prior investigations and/or studies failed to establish proven efficacy and/or safety; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use, except for accepted off-label use of drugs and biologics, consistent with CIGNA policy; or Substantially confined to use in the research setting; or The subject of review or approval by an Institutional Review Board for the proposed use, except as specifically provided in the "Clinical Trials" benefit section; or The subject of an ongoing phase I, II or III clinical trial, except as specifically provided in the "Clinical Trials" benefit section.

- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance including Idiopathic Short Stature Syndrome. However, reconstructive surgery and therapy are covered as provided in the "Reconstructive Surgery" section of Covered Expenses.
- aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non prescribed, except as specifically provided in the "Enteral Nutrition" benefit.
- charges made by a physician/practitioner for broken appointments, phone calls, email or internet evaluations unless otherwise specified in the covered services section of your document.
- any services, supplies or equipment intended primarily to provide a safe environment, including, but not limited to: helmets, safety goggles/glasses, bed exit monitors, restraints, telephone alert systems, fire extinguishers, smoke/carbon monoxide detectors, fall detection systems, safety rails, fixtures to real property to create a safe surrounding, first aid kits, automatic external defibrillators.**]**

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- **[**for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's Family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.**]**

[**Pre-existing Condition Limitations**
Not applicable to anyone under age 19

[For Out-of-Network Coverage Only]
[For treatment other than by a Participating Provider]

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CIGNA will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.]

GENERAL LIMITATIONS
SUPPLEMENTAL MEDICAL BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents for:

- cosmetic surgery which does not meet any of the requirements listed under **Covered Expenses**.
- electrolysis or other hair removal procedures.
- illegal operations or treatments.
- controlled substances, including, but not limited to, marijuana or laetrile.
- nursing services for a normal, healthy infant;
- weight-loss programs for general health, even if a Physician prescribes the program.
- over-the-counter drugs or medications or any drug or medication that does not require a Physician's prescription for use, if used for general well-being or for purely cosmetic purposes.
- nicotine gum or nicotine patches.
- [for the following expenses, although they are considered deductible under Internal Revenue Code, section 213: capital expenses; special equipment installed in an automobile; transportation, except by ambulance when medically necessary; insurance premiums (including long-term care premiums and any insurance amounts included in college or private school tuition); lead-based paint removal; legal fees to authorize treatment for mental illness; or advance payments for lifetime care under an agreement with a retirement home.]

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for [or dental] [or vision]care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred

provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CIGNA will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, CIGNA will determine the following:

(1) CIGNA's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CIGNA will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CIGNA pays charges for benefits that should have been paid by the Primary Plan, or if CIGNA pays charges in excess of those for which we are obligated to provide under the Policy, CIGNA will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CIGNA will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

MEDICARE ELIGIBLES

CIGNA will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

CIGNA will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical [or dental] [or vision] care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty)

because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded

as a benefit reserve for you. CIGNA will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, CIGNA will determine the following:

(1) CIGNA's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CIGNA will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CIGNA pays charges for benefits that should have been paid by the Primary Plan, or if CIGNA pays charges in excess of those for which we are obligated to provide under the Policy, CIGNA will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CIGNA will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

RIGHT OF REIMBURSEMENT

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

LIEN OF THE PLAN

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

ADDITIONAL TERMS

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

PAYMENT OF BENEFITS

To Whom Payable

[Medical] [Medical and Vision] Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of CIGNA's contracts with providers, all claims from contracted providers should be assigned.

CIGNA may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of CIGNA is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, CIGNA may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release CIGNA from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

[Calculation of Covered Expenses

CIGNA, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.]

TERMINATION OF INSURANCE – EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

[**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.]

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

[**Retirement**

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.]

[**TERMINATION OF INSURANCE – DEPENDENTS**

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases[, except when you die].
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

[**Dependent** [**Medical**] [**Vision**] [**Prescription Drug**] [**Medical and Vision**] **Insurance After Your Death**

If you are insured for [Medical] [Vision] [Prescription Drug][[Medical and Vision] Insurance when you die, any of your Dependents who are then insured for such insurance, [except a Dependent who is eligible for Medicare,] will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the last day of the 24th month after your death;
- the date of remarriage of a surviving spouse, if any;
- [the date that Dependent qualifies for Medicare;]
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.]]

TERMINATION OF SUPPLEMENTAL MEDICAL BENEFITS

EMPLOYEES

Your Supplemental Medical Benefits will cease on the earliest date below:

- The date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- The date your coverage under the Employer's Group Medical [and Vision] Benefits Plan ceases.
- The date the Supplemental Medical Benefits policy is canceled.
- The date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

[**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.]

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

[DEPENDENTS

Your Supplemental Medical Benefits for all of your Dependents will cease on the earliest date below:

- The date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance
- The date your coverage under the Employer's Group Medical [and Vision] Benefits Plan ceases.
- The date the Supplemental Medical Benefits policy is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent, as defined under the Employer's Group Medical Benefits Plan.

Any continuation of insurance with premium waiver set forth in the Employer-Sponsored Medical Benefits Plan will not apply to the insurance under this Supplemental Medical Benefits policy.]

Termination of Insurance – Continuation

Special Continuation of Medical Insurance

If your insurance would otherwise cease because of termination of employment or termination of membership in an eligible class, your Medical Insurance will be continued, upon payment of the required premium by you to your Employer, until the earliest of:

- 120 days from the date your insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for medical benefits under another group policy or under Medicare;
- the date the policy is canceled.

If your insurance is being continued as outlined above, the Medical Insurance for your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions set forth above. The Dependent Insurance will be continued until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent, except in the case of change in marital status.

Dependent Insurance After Change in Marital Status

Medical Insurance on your spouse and the eligible Dependents of that spouse, that would otherwise cease due to change in marital status, will be continued until the earliest of:

- 120 days from the date the insurance would otherwise cease due to change in marital status;
- the last day for which the required premium is paid;
- the date the person becomes eligible for medical benefits under another group policy, or under Medicare;
- the date the policy, or Dependent Insurance under it, is canceled;
- the date your insurance ceases.

If, on the day before the Effective Date of this policy, medical insurance was being continued for a person under a group medical policy: (a) sponsored by your Employer; and (b) replaced by this policy, his insurance will be continued under this policy as set forth above.

Your Employer will, within 10 days of the date your insurance would otherwise cease, notify you of your and your eligible Dependent's right to elect continuation as set forth above. You or your eligible Dependent may elect such continuation within 31 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

You and your Dependents are eligible to elect continuation of insurance only if you have been insured under this policy for 3 consecutive months immediately prior to the date insurance would otherwise cease.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply following the termination of insurance.

MEDICAL BENEFITS EXTENSION DURING HOSPITAL CONFINEMENT UPON POLICY CANCELLATION

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- the date Hospital benefits are exhausted.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

THE FOLLOWING WILL APPLY TO RESIDENTS OF ARKANSAS

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CIGNA has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CIGNA's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee

review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CIGNA's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CIGNA will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CIGNA's level two appeal review denial. CIGNA will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CIGNA's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CIGNA.

Appeal to the State of Arkansas

You have the right to contact the Arkansas Insurance Department for assistance at any time. The Consumer Services Division may be contacted at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
501-371-2640
501-371-2749 Fax
or call: 1-800-852-5494

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CIGNA until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

[Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.]

[Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.]

DEFINITIONS

[Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CIGNA for a different amount.]

DEFINITIONS

[Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.]

[Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.]

DEFINITIONS

[Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.]

Dependent

[Dependents are:

- your lawful spouse; [or
- your Domestic Partner; and]
- any child of yours who is
  - [less than [26-99] years old.]
  - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student and primarily supported by you.
  - [26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability [which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage].

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you. [If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.][Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.][Benefits for a Dependent child [or student]will continue until the last day of the calendar year in which the limiting age is reached.]

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.]

Dependent

[Dependents are:

- your lawful spouse; [or
- your Domestic Partner; and]
- any child of yours who is
  - [less than [26-99] years old.]
  - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student and primarily supported by you.
  - [26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability [which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage].

~~[Proof of the child's condition and dependence must be submitted to CIGNA within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA may require proof of the continuation of such condition and dependence.]~~

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you. [If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.][Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.][Benefits for a Dependent child [or student]will continue until the last day of the calendar year in which the limiting age is reached.]

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.]

[Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by CIGNA to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to CIGNA upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.]

DEFINITIONS

[Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.]

[Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.]

[Employer

The term Employer means the Policyholder and all Affiliated Employers.]

[Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.]

DEFINITIONS

[Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.]

DEFINITIONS

[Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.]

DEFINITIONS

[Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.]

DEFINITIONS

[Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.]

DEFINITIONS

[Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CIGNA; and
- fulfills any licensing requirements of the state or locality in which it operates.]

[Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.]

[Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- [receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.]]

DEFINITIONS

[Injury

The term Injury means an accidental bodily injury.]

DEFINITIONS

[In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)]

DEFINITIONS

[Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.]

DEFINITIONS

Include definition if applicable to policyholder plan design.

[Maintenance Medication

In general, a medication is classified as a "maintenance drug" if it:

1. is used in the treatment of chronic illnesses such as asthma, allergies, high blood pressure, etc.; and
2. a reasonable time has elapsed to allow for appropriate therapy stabilization to manage the chronic condition.

There are situations where exceptions to the above definition would apply. These situations include but are not limited to:

- compounded medications requiring the mixing of drugs by a pharmacist.
- any drugs for which home delivery dispensing is prohibited by law.
- prescriptions for which a 90-day supply may not be appropriate as determined by CIGNA, or are prohibited by law (for example certain narcotics or specialty medications).
- Medications that require prior authorization or quantity limits based on Pharmacy & Therapeutics (P&T) Committee established parameters for dosing and dispensing.]

[Maximum Reimbursable Charge - Medical

[Option 1]

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.

[Option 2]

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule developed by CIGNA that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.]

[Option 3]

The Maximum Reimbursable Charge for covered services provided by non-network providers is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- The Average Contracted Rate (ACR). ACR is the average percentage discount applied to all claims in a geographic area paid by CIGNA during a recent 6 month period for the same or similar service/supply provided by CIGNA's network providers. This percentage is applied to the non-network provider's charge to determine the Maximum Reimbursable Charge. The ACR is updated by CIGNA on a semiannual basis. The geographic area used by CIGNA is either a Metropolitan Statistical Areas (MSA) or an area within governmental boundaries (e.g. state, county, zip code).
- In some cases, the ACR amount will not be used and the Maximum Reimbursable Charge is determined based on the lesser of:
- The providers normal charge for a similar service or supply; or
- The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

The Maximum Reimbursable charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.

[Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CIGNA uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The policyholder-selected percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

Additional information about the Maximum Reimbursable Charge is available upon request].

DEFINITIONS

[Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.]

DEFINITIONS

[Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.]

[Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.]

[Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.]

DEFINITIONS

[Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."]

DEFINITIONS

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

DEFINITIONS

Optician

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

DEFINITIONS

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Include definition if applicable to policyholder plan design.

[Orphan Designation

The term Orphan Designation is an FDA classification for drugs pursuant to Section 526 of the Orphan Drug Act (Public Law 97-414 as amended).]

[Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.]

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which CIGNA has contracted [directly or indirectly] to provide prescription services to insureds; [or a designated home delivery Pharmacy with which CIGNA has contracted [directly or indirectly] to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order]**.** *Remove highlighted text if home delivery pharmacy coverage is not included in policyholder plan.*

[Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.]

[Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.]

Pharmacy

The term Pharmacy means a retail Pharmacy, [or a home delivery Pharmacy.**]** *Remove highlighted text if home delivery pharmacy coverage is not included in policyholder plan.*

Pharmacy & Therapeutics (P & T) Committee

A committee of CIGNA Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from [the list of preferred Prescription Drugs and Related Supplies on] the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

DEFINITIONS

[Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.]

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Include definition if applicable to policyholder plan design.

[Preventive Medication

The term Preventive Medication means prescription medications taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered. However, this does not include any drugs or medications used to treat an existing illness, injury or condition.]

DEFINITIONS

[Preventive Treatment

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.]

DEFINITIONS

[Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.]

Include definition if applicable to policyholder plan design.

[Priority Review

The term Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.]

DEFINITIONS

[Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.]

DEFINITIONS

[Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.]

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan,[and spacers for use with oral inhalers].

DEFINITIONS

[Review Organization

The term Review Organization refers to an affiliate of CIGNA or another entity to which CIGNA has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.]

[Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.]

[Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.]

DEFINITIONS

[Specialist [Physician]

The term Specialist [Physician] means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, [obstetrics/gynecology] or pediatrics.]

Include definition if applicable to policyholder plan design.

[Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.]

DEFINITIONS

[Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.]

DEFINITIONS

[Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CIGNA, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.]

DEFINITIONS

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
a CIGNA COMPANY (hereinafter called CIGNA)

CERTIFICATE RIDER

No. CR [1]
[2]

Policyholder: [ABC Company]

Rider Eligibility: [All Insured Employees]

Policy No. or Nos. [A1234567]

[Certificate Rider issued to: [John Doe]]

Effective Date: [September 1, 2010]

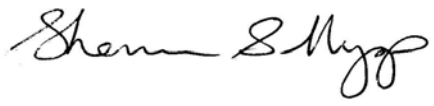
CIGNA will process all claims for benefits while the policy is in effect. CIGNA and the Policyholder are liable for funding benefits as follows:

The Policyholder will fund all benefits in each Policy Month up to an amount agreed upon by the Policyholder and CIGNA. CIGNA will fund benefits in excess of that amount.

When the policy ceases, the Policyholder will fund all policy benefits:

1. for claims incurred before the policy ceases; and
2. for claims incurred after the policy ceases and are payable under any extension of benefits provisions.

This certificate rider forms a part of the certificate issued to you by CIGNA describing the benefits provided under the policy(ies) specified above.



Shermona Mapp, Corporate Secretary

CIGNA HEALTH AND LIFE INSURANCE COMPANY
a CIGNA COMPANY (hereinafter called CIGNA)

CERTIFICATE RIDER

No. CR [1]

[2]

Policyholder: [ABC Company]

Rider Eligibility: [All Insured Employees]

Policy No. or Nos. [A1234567]

[Certificate Rider issued to: [John Doe]]

Effective Date: [September 1, 2010] if you are in Active Service on that date; otherwise, on the date you return to Active Service. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by CIGNA describing the benefits provided under the policy(ies) specified above.

Shermona Mapp, Corporate Secretary

[Insert rider text here.]

Eligibility - Effective Date

Who is Eligible

For Insured Persons

If your coverage under the Previous Plan ceases, you are eligible for coverage under the policy as an Insured Person if:

(1) you are entitled to convert your coverage under the provisions of the Previous Plan as:
- an employee or a member if your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance;
- a Dependent spouse due to divorce, annulment of marriage, or death of the employee or member;
- a Dependent child due to the employee's or member's death or because the child no longer qualifies as a Dependent under the Previous Plan;

(2) your coverage under the Previous Plan ceased for a reason other than failure to make the required contribution toward the cost of the coverage;

(3) you are not eligible for Medicare;

(4) you are not Overinsured;

(5) you are not eligible to be covered as an employee, a member or a Dependent under another group medical care plan sponsored by an employer, union, association or similar entity;

(6) similar benefits are not provided for you or not available to you under any state or federal law.

Who is Eligible

For Dependents

You are eligible to insure any of your Dependents under the policy, if:

(1) you are entitled to convert coverage for your Dependents under the provisions of the Previous Plan;

(2) your coverage for your Dependents under the Previous Plan ceased for a reason other than your failure to make the required contribution toward the cost of the coverage;

(3) your Dependent is not eligible for Medicare;

(4) your Dependent is not Overinsured;

(5) your Dependent is not eligible to be covered as an employee, a member or a dependent under another group medical care plan sponsored by an employer, union, association or similar entity; and

(6) your Dependent is not eligible or is no longer eligible to be covered under any continuation of coverage provision under the terms of the Previous Plan. (This will not apply if the Previous Plan specifically provides a person with the choice to continue his coverage under the Previous Plan or to convert his coverage.)

A person will be eligible to be insured for these benefits as a Dependent on the date he meets the requirements set forth above. However, items 1, 2, and 6 above will not apply to a Dependent who was not covered under the Previous Plan or to a Newly Acquired Dependent.

Effective Date of Insurance

For Insured Persons

If you are eligible as an Insured Person (see the "Eligibility – As an Insured Person" section) you may elect to become insured under the policy for yourself by:

- signing an enrollment form acceptable to CIGNA within 31 days after the date the date you become eligible for the insurance;
- paying the required premium.

The effective date of your insurance will be the date on which you become eligible for the insurance.

If you were covered for your Dependents under the Previous Plan, you must elect to insure your eligible Dependents under the policy.

For Dependents

You may elect to become insured for Dependent Insurance for each of your eligible Dependents (see the "Eligibility – As Dependents" section) only by:

- signing an enrollment form acceptable to CIGNA for that Dependent; and
- paying the required premium for that Dependent.

The effective date of insurance for each Dependent is based upon the following:

(1) With respect to a Dependent who was covered under the Previous Plan, the insurance will be effective on the date the Dependent becomes eligible for it.

(2) If you elect to insure a Newly Acquired Dependent other than a newborn or adopted child or child placed for adoption, within 31 days after the date you become eligible for Dependent Insurance for that Dependent, the insurance will be effective on the date of election.

(3) If you elect to insure a Newly Acquired Dependent who is a newborn or adopted child or child placed for adoption within 31 days after the child's date of birth, adoption or placement for adoption, the insurance will be effective on the child's date of birth, adoption or placement for adoption.

(4) If you elect to insure: (a) a Newly Acquired Dependent more than 31 days after the date you become eligible for Dependent Insurance for the Dependent (including a newborn or adopted child or child placed for adoption); or (b) a Dependent who was not covered under the Previous Plan, the insurance for the Dependent will become effective on the date CIGNA agrees in writing to insured that Dependent.

(5) If the insurance on a Dependent ceases because you stopped making premium payment for that Dependent and you again elect to insure that Dependent, the insurance will become effective on the date CIGNA agrees in writing to insure that Dependent.

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order. You must notify CIGNA and elect coverage for that child within 31 days of the QMCSO being issued.

Under the circumstances described in items 4 and 5 above, CIGNA may require you, at your expense, to submit evidence of the Dependent's good health before it agrees to insure that Dependent.

You will be insured for Dependent insurance only if you are insured for yourself under the policy.

Any reference to an insured Dependent means a Dependent for whom you are insured.

Eligibility - Effective Date

Who is Eligible

For Insured Persons

If your coverage under the Previous Plan ceases, you are eligible for coverage under the policy as an Insured Person if:

(1) you are entitled to convert your coverage under the provisions of the Previous Plan as:

- an employee or a member if your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance;
- a Dependent spouse due to divorce, annulment of marriage, or death of the employee or member;
- a Dependent child due to the employee's or member's death or because the child no longer qualifies as a Dependent under the Previous Plan;

~~(2)you were insured for at least three consecutive months under the Previous Plan or under it and a prior policy issued to the Policyholder;~~

~~(3)~~(2) your coverage under the Previous Plan ceased for a reason other than failure to make the required contribution toward the cost of the coverage;

~~(4)~~(3) you are not eligible for Medicare;

~~(5)~~(4) you are not Overinsured;

~~(6)~~(5) you are not eligible to be covered as an employee, a member or a Dependent under another group medical care plan sponsored by an employer, union, association or similar entity;

~~(7)~~(6) similar benefits are not provided for you or not available to you under any state or federal law.

Who is Eligible

For Dependents

You are eligible to insure any of your Dependents under the policy, if:

(1) you are entitled to convert coverage for your Dependents under the provisions of the Previous Plan;

(2) your coverage for your Dependents under the Previous Plan ceased for a reason other than your failure to make the required contribution toward the cost of the coverage;

(3) your Dependent is not eligible for Medicare;

(4) your Dependent is not Overinsured;

(5) your Dependent is not eligible to be covered as an employee, a member or a dependent under another group medical care plan sponsored by an employer, union, association or similar entity; and

(6) your Dependent is not eligible or is no longer eligible to be covered under any continuation of coverage provision under the terms of the Previous Plan. (This will not apply if the Previous Plan specifically provides a person with the choice to continue his coverage under the Previous Plan or to convert his coverage.)

A person will be eligible to be insured for these benefits as a Dependent on the date he meets the requirements set forth above. However, items 1, 2, and 6 above will not apply to a Dependent who was not covered under the Previous Plan or to a Newly Acquired Dependent.

Effective Date of Insurance

For Insured Persons

If you are eligible as an Insured Person (see the "Eligibility – As an Insured Person" section) you may elect to become insured under the policy for yourself by:

- signing an enrollment form acceptable to CIGNA within 31 days after the date the date you become eligible for the insurance;
- paying the required premium.

The effective date of your insurance will be the date on which you become eligible for the insurance.

If you were covered for your Dependents under the Previous Plan, you must elect to insure your eligible Dependents under the policy.

For Dependents

You may elect to become insured for Dependent Insurance for each of your eligible Dependents (see the "Eligibility – As Dependents" section) only by:

- signing an enrollment form acceptable to CIGNA for that Dependent; and
- paying the required premium for that Dependent.

The effective date of insurance for each Dependent is based upon the following:

(1) With respect to a Dependent who was covered under the Previous Plan, the insurance will be effective on the date the Dependent becomes eligible for it.

(2) If you elect to insure a Newly Acquired Dependent other than a newborn or adopted child or child placed for adoption, within 31 days after the date you become eligible for Dependent Insurance for that Dependent, the insurance will be effective on the date of election.

(3) If you elect to insure a Newly Acquired Dependent who is a newborn or adopted child or child placed for adoption within 31 days after the child's date of birth, adoption or placement for adoption, the insurance will be effective on the child's date of birth, adoption or placement for adoption.

(4) If you elect to insure: (a) a Newly Acquired Dependent more than 31 days after the date you become eligible for Dependent Insurance for the Dependent (including a newborn or adopted child or child placed for adoption); or (b) a Dependent who was not covered under the Previous Plan, the insurance for the Dependent will become effective on the date CIGNA agrees in writing to insured that Dependent.

(5) If the insurance on a Dependent ceases because you stopped making premium payment for that Dependent and you again elect to insure that Dependent, the insurance will become effective on the date CIGNA agrees in writing to insure that Dependent.

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order. You must notify CIGNA and elect coverage for that child within 31 days of the QMCSO being issued.

Under the circumstances described in items 4 and 5 above, CIGNA may require you, at your expense, to submit evidence of the Dependent's good health before it agrees to insure that Dependent.

You will be insured for Dependent insurance only if you are insured for yourself under the policy.

Any reference to an insured Dependent means a Dependent for whom you are insured.

Subrogation

To the extent that benefits are provided or paid under this Policy, CIGNA will be subrogated to all rights of recovery which you may acquire against any other party for the recovery of the amount paid under this Policy; however, CIGNA's right of subrogation is second to your right to be fully compensated for damages. You agree to deliver all necessary documents or papers, to execute and deliver all necessary instruments, to furnish information and assistance, and to take any action CIGNA may require to facilitate enforcement of CIGNA's right of subrogation. CIGNA agrees to pay its portion of your attorneys' fees or other costs associated with a claim or lawsuit, to the extent that CIGNA recovers any portion of the benefits paid under this Policy pursuant to its right of subrogation.

Right of Reimbursement

To the extent that benefits are provided or paid under this Policy, you agree that if you fully recover damages from a third party, you will reimburse CIGNA the portion of the damages recovered for the expenses incurred by you that were provided or paid by CIGNA. CIGNA agrees to pay its portion of your attorneys' fees or other costs associated with a claim or lawsuit to the extent that CIGNA recovers any portion of the benefits paid under this Policy, pursuant to its right of reimbursement.

Conversion for Surviving Spouse and Dependents

Upon the death of the policyholder conversion coverage will be available to the covered surviving spouse and to any covered dependents.

Written request for conversion and payment of the first monthly premium must be made within 31 days after termination of insurance under this Policy. Coverage shall commence as of the date insurance was terminated under this Policy.

Termination of Insurance

Insured Persons

Your insurance will cease on the earliest date below:

(1) the date the policy is cancelled

(2) The date you cease to be eligible as described in the "Who is Eligible – For Insured Persons" section;

(3) The date you become eligible to be covered as an employee, member or dependent under a group medical care plan sponsored by an employer, union, association or similar entity;

(4) The last day ~~end of the period~~ for which you have made any required contribution for the insurance.~~paid the required premium.~~

Notice of Cancellation of Medical Insurance

CIGNA will send you written notice at least 15 days prior to the end of the grace period stating that if the premium has not been paid by the end of the grace period, the policy will be cancelled due to non-payment of premium.

Dependents

Your insurance on any one of your Dependents will cease on the earliest date below:

(1) The date your insurance ceases for any reason except for your death.

(2) The date the Dependent ceases to be eligible as described in the section entitled, "Eligibility for Insurance – For Dependents".

(3) The date the Dependent becomes eligible to be covered as an employee, member or Dependent under a group medical care plan sponsored by an employer, union, association or similar entity.

(4) The end of the period in which you have died, provided the required premium has been paid for the Dependent for that period.

(5) The last day ~~end of the period~~ for which you have made any required contribution for the insurance ~~paid the required premium~~ for the Dependent.

The Dependent may be eligible to be insured as an Insured Person under the terms of the section entitled, "Eligibility for Insurance – For Insured Persons."

Termination of Insurance

Insured Persons

Your insurance will cease on the earliest date below:

(1) the date the policy is cancelled

(2) The date you cease to be eligible as described in the "Who is Eligible – For Insured Persons" section;

(3) The date you become eligible to be covered as an employee, member or dependent under a group medical care plan sponsored by an employer, union, association or similar entity;

(4) The last day for which you have made any required contribution for the insurance.

Notice of Cancellation of Medical Insurance

CIGNA will send you written notice at least 15 days prior to the end of the grace period stating that if the premium has not been paid by the end of the grace period, the policy will be cancelled due to non-payment of premium.

Dependents

Your insurance on any one of your Dependents will cease on the earliest date below:

(1) The date your insurance ceases for any reason except for your death.

(2) The date the Dependent ceases to be eligible as described in the section entitled, "Eligibility for Insurance – For Dependents".

(3) The date the Dependent becomes eligible to be covered as an employee, member or Dependent under a group medical care plan sponsored by an employer, union, association or similar entity.

(4) The end of the period in which you have died, provided the required premium has been paid for the Dependent for that period.

(5) The last day for which you have made any required contribution for the insurance for the Dependent.

The Dependent may be eligible to be insured as an Insured Person under the terms of the section entitled, "Eligibility for Insurance – For Insured Persons."

DEFINITIONS

Group Health Plan

An "eligible individual" must have his or her most recent coverage under a group health plan. A group health plan is considered an employee welfare benefit plan, to the extent that the plan provides medical care to employees or their dependents directly or through reimbursement, and shall include a governmental plan or a church plan. Governmental plans are for employees of government entities, not public welfare or other benefit plans such as Medicare, Medicaid or Indian Health Service (IHS).

DEFINITIONS
Policy Year

The first policy year begins on the effective date of coverage, shown on the Policy Page, and ends 12 months later.

Subsequent policy years begin on the policy anniversary dates and end 12 months later.

DEFINITIONS

Policy

Policy means this document which describes:

1. The insurance benefits to which a Covered Person is entitled.
2. To whom the benefits are payable.
3. Limitations or requirements that may apply.
4. Who is eligible for coverage under the policy and when they are eligible.

DEFINITIONS

Application

The individual application is the document showing information about the policyholder and his/her dependents concerning benefits and health conditions. The individual application is part of the policy.

DEFINITIONS

Overinsured

A person will be considered Overinsured if:

- his coverage under the Previous Plan is replaced by similar group coverage within 31 days; or
- the benefits under the policy, combined with Similar Benefits, result in an excess of insurance based on CIGNA's underwriting standards. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law (except Medicaid).

DEFINITIONS

Previous Plan

The term Previous Plan means a group health care plan which provides Basic and Major Medical Benefits or Comprehensive Medical Benefits under (a) a group medical insurance policy issued by CIGNA (b) a plan of self-insurance for which CIGNA furnishes administrative services and has agreed to provide medical conversion benefits; or (c) a health maintenance organization for which CIGNA has agreed to provide medical conversion benefits.

Mailing Address: Hartford, Connecticut 06152
Home Office: Bloomfield, Connecticut

CIGNA Health and Life Insurance Company, a CIGNA company (hereinafter referred to as CIGNA)

Medical Plan

Policyholder: (hereinafter called you): [John Doe
123 Main Street]

Policy Number: **[A1234567]** Policy Effective Date: **[September 1, 2010]**

This Policy is issued in consideration of your application and payment of the first premium. The provisions of this Policy and the attached application, and any attached papers constitute the entire contract. We agree to pay benefits as provided within for you or any Covered Person.

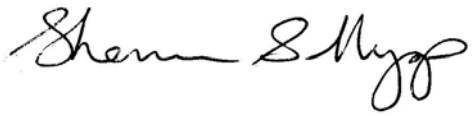
Effective Date: This Policy is effective from 12:01 a.m. at your address, on the Effective Date shown above.

This policy is issued in [situs state name] and shall be governed by its laws.

This policy contains the terms under which the Insurance Company agrees to insure certain individuals and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

Executed by CIGNA Health and Life Insurance Company, a CIGNA Company as of _____(Date)_____.



Shermona Mapp, Corporate Secretary

PREMIUMS

Premium Payment

The first premium for you and your Dependents, if any, will be due on your Participation Date. After that, your premiums will be due quarterly. Premiums are payable at CIGNA's Home Office or to an authorized agent of CIGNA.

Premium Due Date

Your Premium Due Date will occur quarterly. Your Premium Due Date will be the day of the month with the same number as your Participation Date or the last day of a month in which there is no day with the same number as your Participation Date.

Premium Statement

A Premium Statement will be prepared as of your Premium Due Date. It will show the premium due for you and your Dependents, if any. This Premium Statement will reflect any pro rata premium charges or credits due to changes in the number of your insured Dependents and changes in the number of your insured Dependents and changes in insurance amounts that took place in the preceding quarter.

Changes in Premium Rates

Any premium rate may be changed by CIGNA on your Premium Due Date. No change in rates will be made until 12 months after your Participation Date. An increase in rates will not be made more often than once in any 6 month period following the first 12-month period.

However, CIGNA may change rates immediately, if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under this policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If a change in rates takes place on a date that is not your Premium Due Date, a pro rata adjustment will be made. The pro rata adjustment will apply for the change in rates from the date of the change to your next Premium Due Date.

CIGNA will provide written notice at least 45 days prior to any rate increase of 20 percent or more.

Grace Period

If, before your Premium Due Date, you have not given written notice to CIGNA that you cancel the insurance under the policy for yourself or for your Dependents, a Grace Period of 31 days will be granted for each premium due after the initial premium. The insurance on you and your Dependents will stay in effect during the Grace Period. If any premium of yours is not paid by the end of the Grace Period, the insurance on you and your Dependents will automatically be cancelled as of your last Premium Due Date. If you have given written notice in advance of an earlier date of cancellation, the insurance on you and your Dependents will be cancelled as of that earlier date. You will be liable to CIGNA for any unpaid premium for the time the insurance on you and your Dependents was in force.

Reinstatement

The insurance on you and your Dependents, if any, will be reinstated if: (a) you pay the overdue premium within 3 months after the end of the Grace Period; and (b) you, at your own expense, submit evidence of good health acceptable to CIGNA for yourself and each of your Dependents.

The Reinstatement Date will be the date on which CIGNA: (a) accepts the payment of the overdue premium; and (b) agrees, in writing, to again insure you and your Dependents under this policy.

The insurance, as reinstated, on you and your dependents will cover only: (a) Injuries sustained after the Reinstatement Date; and (b) Sickness beginning more than 10 days after the Reinstatement Date. In all other respects, CIGNA and you will have the same rights after the Reinstatement Date as CIGNA and you had before the due date of the defaulted premium. Any premiums accepted in connection with a reinstatement will be applied to a period for which premium has not already been paid.

MISCELLANEOUS PROVISIONS

INSURANCE DATA

You will give CIGNA all of the data necessary to calculate the premium for the insurance on yourself and your Dependents, if any, and all other data that it may reasonably require.

INCORRECT PREMIUM

Premiums paid in error will be refunded without interest when requested by you.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application and any attached amendments constitutes the entire contract of insurance.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the covered person and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

CONSENT OF BENEFICIARY: Consent of the beneficiary shall not be requisite to surrender or assignment of this policy, nor to change of beneficiary, nor to any other changes in this policy.

TIME LIMIT ON CERTAIN DEFENSES: (a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three year period. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three year period.

EXTENSION OF TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which you reside, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

STATEMENTS NOT WARRANTIES. All statement made by you will, in the absence of fraud be deemed representations and not warranties. No statement made by you to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by you and a copy is sent to you or your beneficiary.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on the date of issue, is in conflict with the statutes of the state in which the insured resides at the date of issue is understood to be amended to conform to such statutes.

PHYSICIAN/PATIENT RELATIONSHIP. You will have the right to choose any Physician who is practicing legally. CIGNA will in no way disturb the Physician/patient relationship.

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/14/2010

Comments:

Attachments:

AR Certif of Compliance with Rule 19.pdf

AR NAIC Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/14/2010

Comments:

Attachment:

HP-APP-1 cat # 831494 (Generic).pdf

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/14/2010

Comments:

Attachment:

AR Final PPACA Uniform Compliance Sumary.pdf

		Item Status:	Status Date:
Satisfied - Item:	CHLIC Forms Listing	Approved-Closed	09/14/2010

Comments:

Attachment:

AR SERFF - CHLIC Forms Listing (Medical, Rx and Vision) - 06-29-10.pdf

		Item Status:	Status Date:

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Satisfied - Item: Statement of Variability Approved-Closed 09/14/2010

Comments:

Attachment:

SERFF - CHLIC (Medical, Pharmacy and Vision) Statement of Variability - 04-20-10.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: CIGNA Health and Life Insurance Company

Form Number(s): HP-APP1 et al (See attached forms listing)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Edmund J. Skowronek, Jr.
Name

Director
Title

July 16, 2010
Date

CIGNA HEALTH AND LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with state readability laws and regulations and the NAIC Life and Health Insurance Policy Language Simplification Model Act.

A. Option Selected

Policy and related forms are scored collectively for the Flesch reading ease test. The collective score for the policy forms and each related form is indicated below:

Form and Form Numbers to Which Certification is Applicable:

HForm Number	Flesch Score
HP-APP-1 et. al.	46.9

B. Test Option Selected

Test was applied to individual policy insert pages(s) and individual certificate insert pages(s).

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score of 40 on the Flesch reading ease test in accordance with section A above.

2. It is printed in not less than ten-point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

3. The layout and spacing separate the paragraphs from each other and from the border of the paper.

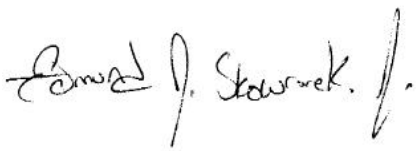
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.

6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

7. A table of contents or an index of the principal sections is included in the policy.

8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.



Edmund J. Skowronek, Jr.	Director	July 16, 2010
	Officer's Title	Date

Application

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CIGNA

1. Name of Applicant	2. Main Address
3. Nature of Business	
4. Classes and Locations of Individuals Eligible	5. Subsidiary and Affiliated Companies Included

6. Total Number of Individuals Eligible	For Individual Benefits	For Dependent Benefits

Have any of the classes of individuals eligible been covered under a group insurance policy or any other form of group plan within the past five years?
☐ Yes ☐ No *If so, please specify the benefits, the underwriting company or organization, and the dates these benefits were terminated.*

7. Group Insurance Applied For: *(Please check all that apply)*

Individual	Dependent		Individual	Dependent	
☐	☐	Life Insurance	☐	☐	Doctors Attendance Benefits
☐	☐	Accidental Death & Dismemberment Insurance	☐	☐	Laboratory and X-ray Examination Benefits
☐	—	Short Term Disability Insurance	☐	☐	Major Medical Benefits
☐	—	Long Term Disability Insurance	☐	☐	Comprehensive Medical Benefits
☐	☐	Hospital Benefits	☐	☐	Dental Benefits
☐	☐	Surgical Benefits	☐	☐	Vision Care Benefits
☐	☐	_____			

8. Effective Date Requested: _____

Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect on the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If this Application is not accepted, no insurance will become effective. Any premium advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

9. THE APPLICANT DECLARES: that he has read the above statement and the answers to the above questions are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that the terms and conditions of the Insurance Company's Proposal for the Group Insurance applied for forms a part of this Application and that this Application will form a part of any policy(s) issued; (3) that only the information on this Application will bind the Insurance Company; and (4) that no waiver or change will bind the Insurance Company unless signed by an Executive Officer of the Insurance Company. Group Insurance will only be provided for persons eligible under the policy(s) issued.

Dated at _____ on _____

Name of Applicant _____

By _____ Title _____

Witness _____ Soliciting Agent if other than Witness _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATEMENT TO BE SIGNED BY APPLICANT UPON PAYMENT OF THE PREMIUM OR ANY PART THEREOF

I HEREBY DECLARE that I have paid to _____ Agent

_____ Dollars for which I hold his receipt.

Date _____ Applicant _____

Agent _____ Agent's License No. _____

Conditional Receipt

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

CIGNA

Received of _____ Dollars

to be applied against the first premium on the proposed Group Insurance under this Application. This payment is made and accepted subject to the following conditions. Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect as of the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If the Application is not accepted, no insurance will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

Date _____ Agent _____ Agent's License No. _____

DETACH THIS RECEIPT WHEN PAYMENT IS MADE

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				☐ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Text has been added to note that any Pre-existing Condition Limitation is "Not applicable to anyone under age 19."			
	Page Number: Form HC-EXC3			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Schedule text accommodates different Annual Maximums for essential vs. non-essential benefits			
	Page Number: HC-SOC135 and HC-SOC136			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: Schedule text accommodates different Lifetime Maximums for essential vs. non-essential benefits			
	Page Number: HC-SOC135 and HC-SOC136			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: CIGNA does not rescind coverage.			
	Page Number: N/A			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation: Schedule provides for no cost-sharing for preventive services			
	Page Number: HC-SOC135 and HC-SOC136			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Revisions have been made to the Dependent definition to provide for coverage for dependents until age 26 (at a minimum).			
	Page Number: HC-DFS46			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: CIGNA provides for both an internal appeal and external review process.			
	Page Number: HC-APL22			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: CIGNA provides coverage for emergency services without a prior authorization requirement, at the In-Network cost-sharing level.			
	Page Number: HC-SOC135, HC-SOC136 and HC-DFS6			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: CIGNA standardly allows pediatricians to be designated PCPs.			
	Page Number: HC-DFS40			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Generally, CIGNA's products are "open access" and do not require prior authorization or referral to see and OB/GYN. If a product does require a referral to a specialist, CIGAN standardly permits direct access to OB/GYNs.			
	Page Number: HCIMP3			

CIGNA Health and Life Insurance Company

Listing of Forms Submitted for Approval

Policy Forms

HP-APP-1 .....Policy Application
HP-POL3 .....Policy
HP-AMD1.....Policy Amendment – General Use
HP-AMD2.....Policy Amendment/Rider – Minimum Premium

Certificate Forms

HC-TOC1.....Table of Contents
HC-CER1.....Certification
HC-SPP1.....Introduction (for use with Preferred Provider or Exclusive Provider Plans)
HC-SPP2.....Case Management
HC-SPP3.....Additional Programs
HC-SPP4.....Appeals Notice
HC-SPP5.....Emergency and Urgent Care Notice
HC-IMP24 .....Important Notices
HC-CLM1.....How to File Your Claim
HC-ELG1.....Eligibility – Effective Date
HC-ELG2.....Eligibility – Effective Date (Supplemental Medical Benefits)
HC-IMP1 .....Important Information About Your Medical Benefits (for use with Open Access Plus or Open Access Plus in-Network plans)
HC-IMP3 .....Important Information About Your Medical Benefits (for use with Network, Network Open Access, Point of Service or Point of Service Open Access plans)
HC-SOC135.....Schedule of Insurance (for use with Point of Service, Point of Service Open Access, Preferred Provider or Open Access Plus plans)
HC-SOC136.....Schedule of Insurance (for use with Network, Network Open Access, Exclusive Provider, Open Access Plus In-Network or Comprehensive Medical plans)
HC-PAC1.....Certification Requirements (for use with Point of Service, Point of Service Open Access, Preferred Provider, Open Access Plus or Comprehensive Medical plans)
HC-PRA1 .....Prior Authorization
HC-COV145 .....Covered Expenses
HC-COV2 .....Covered Expenses (continued) (coverage of morbid obesity)
HC-COV3 .....Covered Expenses (continued) (coverage of orthognathic surgery)
HC-COV4 .....Covered Expenses (continued) (coverage of cardiac rehabilitation)
HC-COV5 .....Covered Expenses (continued) (Home Health Services)
HC-COV6 .....Covered Expenses (continued) (Hospice Care Services)
HC-COV7 .....Covered Expenses (continued) (Mental Health and Substance Abuse Services)
HC-COV8 .....Covered Expenses (continued) (Durable Medical Equipment)
HC-COV9 .....Covered Expenses (continued) (External Prosthetic Appliances and Devices)
HC-COV10 .....Covered Expenses (continued) (Infertility Services – Option I)
HC-COV11 .....Covered Expenses (continued) (Infertility Services – Option II)
HC-COV12 .....Covered Expenses (continued) (Short-Term Rehabilitative Therapy and Chiropractic Care Services)

CIGNA Health and Life Insurance Company

Listing of Forms Submitted for Approval

HC-COV13	Covered Expenses (continued) (Short-Term Rehabilitative Therapy/Chiropractic Care Services)
HC-COV14	Covered Expenses (continued) (Breast Reconstruction and Breast Prostheses/Reconstructive Surgery)
HC-COV15	Covered Expenses (continued) (Transplant Services)
HC-COV16	Covered Expenses (continued) (Prescription Drug Benefits – covered under Medical)
HC-MRP1	Supplemental Medical Benefits (Covered Expenses, etc.)
HC-CNV1	Medical Conversion Privilege
HC-SOC116	Prescription Drug Benefits – The Schedule
HC-PHR1	Prescription Drug Benefits – Covered Expenses
HC-PHR2	Prescription Drug Benefits – Limitations
HC-PHR3	Prescription Drug Benefits – Your Payments
HC-PHR4	Prescription Drug Benefits – Exclusions
HC-PHR5	Prescription Drug Benefits – Reimbursement-Filing a Claim
HC-VIS1	Vision – Covered Expenses
HC-VIS2	Vision – Expenses Not Covered
HC-VIS3	Vision – Covered Expenses & Exclusions
HC-VIS4	Vision – Covered Expenses, Limitations & Expenses Not Covered
HC-VIS5	Vision – Schedule of Vision Benefits
HC-EXC1	Exclusions, Expenses Not Covered and General Limitations
HC-EXC3	Exclusions, Expenses Not Covered and General Limitations – Pre-existing Condition Limitation
HC-MRP2	Supplemental Medical Benefits – General Limitations
HC-COB1	Coordination of Benefits
HC-COB3	Coordination of Benefits – Non-Duplication of Benefits
HC-SUB2	Expenses for Which a Third Party May Be Responsible
HC-POB1	Payment of Benefits
HC-TRM1	Termination of Insurance
HC-TRM58	Termination of Insurance
HC-TRM2	Termination of Supplemental Medical Benefits
HC-BEX20	Medical Benefits Extension
HC-APL22	When You Have a Complaint or Appeal
HC-DFS1	Active Service
HC-DFS2	Bed And Board
HC-DFS3	Charges
HC-DFS55	Chiropractic Care
HC-DFS4	Custodial Services
HC-DFS5	Custodial Services
HC-DFS46	Dependent
HC-DFS47	Domestic Partner
HC-DFS6	Emergency Services/Emergency Medical
HC-DFS7	Employee
HC-DFS8	Employer
HC-DFS9	Employer Trustee
HC-DFS10	Expense Incurred
HC-DFS11	Free-Standing Surgical Facility
HC-DFS51	Hospice Care Program
HC-DFS52	Hospice Care Services

CIGNA Health and Life Insurance Company

Listing of Forms Submitted for Approval

HC-DFS53 .....Hospice Facility
HC-DFS48 .....Hospital
HC-DFS49 .....Hospital Confinement Or Confined In A Hospital
HC-DFS12 .....Injury
HC-DFS37 .....In-Network/Out-of-Network
HC-DFS56 .....Maintenance Treatment
HC-DFS58 .....Maintenance Medication
HC-DFS13 .....Maximum Reimbursable Charge
HC-DFS14 .....Maximum Reimbursable Charge
HC-DFS16 .....Medicaid
HC-DFS17 .....Medicare
HC-DFS19 .....Medically Necessary
HC-DFS21 .....Necessary Services or Supplies
HC-DFS22 .....Nurse
HC-DFS70 .....Ophthalmologist
HC-DFS71 .....Optician
HC-DFS72 .....Optometrist
HC-DFS59 .....Orphan Designation
HC-DFS23 .....Other Health Care Facility
HC-DFS60 .....Participating Pharmacy
HC-DFS45 .....Participating Provider
HC-DFS18 .....Participation Date
HC-DFS61 .....Pharmacy
HC-DFS62 .....Pharmacy and Therapeutics Committee
HC-DFS25 .....Physician
HC-DFS63 .....Prescription Drug
HC-DFS64 .....Prescription Drug List
HC-DFS65 .....Prescription Order
HC-DFS66 .....Preventive Medication
HC-DFS57 .....Preventive Treatment
HC-DFS40 .....Primary Care Physician
HC-DFS67 .....Priority Review
HC-DFS26 .....Psychologist
HC-DFS27 .....Psychologist
HC-DFS68 .....Related Supplies
HC-DFS30 .....Review Organization
HC-DFS50 .....Sickness
HC-DFS31 .....Skilled Nursing Facility
HC-DFS33 .....Specialist
HC-DFS69 .....Specialty Medication
HC-DFS54 .....Terminal Illness
HC-DFS34 .....Urgent Care
HC-DFS73 .....Vision Provider

HC-MPR1 .....Minimum Premium Rider
HC-RDR1 .....Certificate Rider – General Use
HC-RDR4 .....Certificate Rider – General Use

CIGNA Health and Life Insurance Company

Listing of Forms Submitted for Approval

HC-ELG7	Eligibility Effective Date for Conversion Policy
HC-SUB6	Subrogation for Conversion Policy
HC-TRM9	Continuation for Surviving Spouse/Dep for Conversion Policy
HC-TRM10	Termination for Conversion Policy
HC-DFS91	Group Health Plan for Conversion Policy
HC-DFS92	Policy Year for Conversion Policy
HC-DFS93	Policy for Conversion Policy
HC-DFS94	Application for Conversion Policy
HC-DFS108	Overinsured for Conversion Policy
HC-DFS109	Previous Plan for Conversion Policy
HP-POL53	Certification for Conversion Policy
HP-POL54	Premiums/Miscellaneous and General Provisions for Conversion Policy

CIGNA Health and Life Insurance Company

Statement of Variability
Forms HP-POL et al. and HC-TOC et al.

General

1. To the extent that variable changes are made, they will not be ambiguous or deceptive.

2. Titles or names – such as the product name – may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Fill in text has been presented in "John Doe" format.

4. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.

5. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to: benefit provisions may be rewritten at the request of a Policyholder to clarify the Policyholder's understanding of benefits and/or administration.

6. Schedule items may be varied to reflect Policyholder election (e.g. a "copay" cost sharing option is elected for a coverage item rather than a "coinsurance" cost-sharing option). Possible numerical values available to Policyholder's are expressed by a defined range in the Schedule (i.e., a copayment dollar amount range, a coinsurance percentage range, a day or visit maximum range or contract, calendar year or lifetime dollar maximum range). Policyholders may elect any numerical value within the identified range.

7. Proposed Exclusion text has been marked variable to allow a Policyholder to include all, or some, of the proposed exclusions.

8. Proposed Covered Expenses text has been marked variable to allow a Policyholder to include all, or some, of the proposed coverage items.

Specific Forms

Form HC-TOC1: Table of Contents

- Table of Contents entries vary based on Policyholder coverage elections.

Form HC-CER1: Certification

- "Notice" language may be included for a Section 125 plan or when a Policyholder elects a "Name: certificate, as appropriate.

Form HC-SPP1 et al: Special Plan Provisions

- Provisions will be included or deleted, based on Policyholder plan design election.

Form HC-CLM1: How to File Your Claim

- The page, in its entirety, may be removed for a Prescription Drug or Vision Standalone plan.

Form HC-ELG1 et al.: Eligibility – Effective Date

- Include text relating to Dependents, if coverage of Dependents is elected by the Policyholder.
- Text may be varied to reflect the appropriate description of Class of Eligible Employee based on Policyholder specification (e.g. "All Hourly Employees").
- Include references to Vision benefits according to Policyholder coverage elections.
- Text regarding "Initial Employee Group" and "New Employee Group" will be removed for a renewed certificate.
- Applicable time periods may vary within the range shown.
- Text regarding the Participation Date of the Employer will be used for plans issued to a Trust.

Form HC-IMP1 et al.: Important Information About Your Medical Plan

- The page, in its entirety, may be removed for a Prescription Drug or Vision Standalone plan.
- Text regarding the requirement to select a Primary Care Physician (PCP) and Direct Access for Chiropractic Care Services will be included based on Policyholder election.
- Regardless of Policyholder election, Direct Access for OB/GYN services is always permitted.
- Open Access plans provide an optional PCP election or simply recommend a PCP designation (based on Policyholder plan election), as well as providing direct access to Participating Physicians – including Specialty Physicians – without a referral.

Form HC-PAC1: Certification Requirements

- References to "Out of Network" will be removed for Comprehensive Medical plans.
- Reference to Mental Health Residential Treatment Services will be included or deleted, based on Policyholder plan feature election.
- Policyholder may elect a 50% reduction penalty or a dollar penalty for Hospital admissions. Dollar penalty may vary within the range shown.
- Policyholder may elect a denial penalty or a 50% reduction penalty for a continued stay.
- Remove Outpatient Certification Requirement section if this program is not elected by the Policyholder.
- Policyholder may elect a 50% reduction penalty or a dollar penalty for outpatient testing or procedures. Dollar penalty may vary within the range shown.
- Policyholder may elect a denial penalty or a 50% reduction penalty for outpatient resting or procedures performed, but not Medically Necessary.
- Outpatient tests or procedures subject to certification may vary based on program enhancements.

Form HC-PRA1: Prior Authorization/Pre-Authorized

- Service subject to prior authorization may vary based on program enhancements.
- Include reference to outpatient facility services and advanced radiological imaging based on Policyholder certification program election.
- Remove reference to intensive outpatient programs based on Policyholder plan feature election.

Form HC-COV1 et al.: Covered Expenses

- Add bracketed text pieces per Policyholder plan specification.
- The term "Chemical Dependency" may be substituted for the term "Substance Abuse."
- Where similar text options are available such as Infertility Options I and II, text will reflect Policyholder plan specification.
- Include Supplemental Medical Benefits page when this program is elected by the Policyholder.
- For Supplemental Medical Benefits, include text relating to Dependents/Families, if coverage of Dependents is elected by the Policyholder.
- For Supplemental Medical Benefits, Calendar Year maximum may vary within the range shown, based on Policyholder election.
- For Supplemental Medical Benefits, include bulleted items two through nine based on Policyholder plan specification.
- For Supplemental Medical Benefits, include bulleted items two through ten based on Policyholder plan specification.

Form HC-CNV1: Medical Conversion Privilege

- The page, in its entirety, may be removed for a Prescription Drug or Vision Standalone plan.

Form HC-PHR1 et al.: Prescription Drug Benefits

- Text will vary in accordance with italicized descriptions on the pages. Variable text may be included or excluded to reflect policyholder election or plan design.

Form HC-VIS1 et al.: Vision Benefits

- Add bracketed text pieces per Policyholder plan specification (e.g. exam only coverage, exam, lens & frame coverage etc.).
- Text will vary in accordance with the descriptions on the pages. Variable text may be included or excluded to reflect policyholder election or plan design.
- The vision benefit may be embedded in the group medical and/or dental plan as an optional product feature or as a standalone product. `
- The terms "Exam" or "Vision Exam" may be substituted for the term "Examination."
- The term "Copay" may be substituted for the term "Copayment"
- Where similar text options are available such as options for Exams, Lenses, Contact Lenses & Frames, text will reflect Policyholder plan specification.
- Include Covered Expenses (HC-VIS1), Expenses Not Covered (HC-VIS2), Covered Expenses & Exclusions (HC-VIS3) and Covered Expenses, Limitations & Expenses Not Covered (HC-VIS4) pages depending on what is elected by the Policyholder.
- Exclusion text has been marked variable to allow a Policyholder to include all, or some, of the proposed exclusions.
- Schedule items will be varied to reflect Policyholder election (e.g. exam, lenses, frames, contact lenses, copayments, allowances, maximums and frequency). Possible numerical values available to Policyholder's are expressed by a defined range in the Schedule (i.e., a copayment dollar amount range, a coinsurance percentage range, a maximum dollar amount range, an allowance dollar amount range or contract or calendar year frequency maximum range). Policyholders may elect any numerical value within the identified range.

Form HC-EXC1 et al.: Exclusions, Expenses Not Covered and General Limitations

- Include Supplemental Medical Benefits page when this program is elected by the Policyholder.
- For Supplemental Medical Benefits, include bulleted items based on Policyholder plan specification.
- For Medical Benefits, include bulleted items based on Policyholder plan specifications.

Form HC-COB1: Coordination of Benefits

- References to Medicare Eligibles will be removed if Policyholder elects not to coordinate benefits with Medicare.

Form HC-POB1: Payment of Benefits

- The page, in its entirety, may be removed for a Prescription Drug or Vision Standalone plan.
- Plan coverage references may vary based on Policyholder election.
- Bracketed text will be included or deleted, based on Policyholder election.

Form HC-TRM1 et al.: Termination of Insurance

- Include text relating to Dependents, if coverage of Dependents is elected by the Policyholder.
- Plan coverage references may vary based on Policyholder election.
- Include Retirement provision if Policyholder elects coverage for retired employees.
- Include provision regarding Temporary Layoff based on Policyholder election.

Form HC-DFS1 et al.: Definitions

- Include definitions necessary to describe coverage based on Policyholder election.
- Add bracketed text pieces per Policyholder plan specification.

SERFF Tracking Number:	*CCGH-126653734*	*State:*	*Arkansas*
Filing Company:	*CIGNA Health and Life Insurance Company*	*State Tracking Number:*	*46221*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*Group Medical Benefits*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/16/2010	Form	Eligibility Effective Date for Conversion Policy	08/25/2010	HC-ELG7.pdf (Superceded)
08/25/2010	Form	Termination for Conversion Policy	09/10/2010	HC-TRM10 REVISION V1.pdf (Superceded) HC-TRM10 REDLINE REVISION V1.pdf (Superceded)
06/16/2010	Form	Termination for Conversion Policy	08/25/2010	HC-TRM10.pdf (Superceded)
06/16/2010	Form	Eligibility – Effective Date	08/25/2010	HC-ELG1.pdf (Superceded)
06/16/2010	Form	Medical Conversion Privilege	08/25/2010	HC-CNV1.pdf (Superceded)
06/16/2010	Form	Dependent	08/25/2010	HC-DFS46.pdf (Superceded)

Eligibility - Effective Date

Who is Eligible

For Insured Persons

If your coverage under the Previous Plan ceases, you are eligible for coverage under the policy as an Insured Person if:

(1) you are entitled to convert your coverage under the provisions of the Previous Plan as:
- an employee or a member if your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance;
- a Dependent spouse due to divorce, annulment of marriage, or death of the employee or member;
- a Dependent child due to the employee's or member's death or because the child no longer qualifies as a Dependent under the Previous Plan;

(2) you were insured for at least three consecutive months under the Previous Plan or under it and a prior policy issued to the Policyholder;

(3) your coverage under the Previous Plan ceased for a reason other than failure to make the required contribution toward the cost of the coverage;

(4) you are not eligible for Medicare;

(5) you are not Overinsured;

(6) you are not eligible to be covered as an employee, a member or a Dependent under another group medical care plan sponsored by an employer, union, association or similar entity;

(7) similar benefits are not provided for you or not available to you under any state or federal law.

Who is Eligible

For Dependents

You are eligible to insure any of your Dependents under the policy, if:

(1) you are entitled to convert coverage for your Dependents under the provisions of the Previous Plan;

(2) your coverage for your Dependents under the Previous Plan ceased for a reason other than your failure to make the required contribution toward the cost of the coverage;

(3) your Dependent is not eligible for Medicare;

(4) your Dependent is not Overinsured;

(5) your Dependent is not eligible to be covered as an employee, a member or a dependent under another group medical care plan sponsored by an employer, union, association or similar entity; and

(6) your Dependent is not eligible or is no longer eligible to be covered under any continuation of coverage provision under the terms of the Previous Plan. (This will not apply if the Previous Plan specifically provides a person with the choice to continue his coverage under the Previous Plan or to convert his coverage.)

A person will be eligible to be insured for these benefits as a Dependent on the date he meets the requirements set forth above. However, items 1, 2, and 6 above will not apply to a Dependent who was not covered under the Previous Plan or to a Newly Acquired Dependent.

Effective Date of Insurance

For Insured Persons

If you are eligible as an Insured Person (see the "Eligibility – As an Insured Person" section) you may elect to become insured under the policy for yourself by:

- signing an enrollment form acceptable to CIGNA within 31 days after the date the date you become eligible for the insurance;
- paying the required premium.

The effective date of your insurance will be the date on which you become eligible for the insurance.

If you were covered for your Dependents under the Previous Plan, you must elect to insure your eligible Dependents under the policy.

For Dependents

You may elect to become insured for Dependent Insurance for each of your eligible Dependents (see the "Eligibility – As Dependents" section) only by:

- signing an enrollment form acceptable to CIGNA for that Dependent; and
- paying the required premium for that Dependent.

The effective date of insurance for each Dependent is based upon the following:

(1) With respect to a Dependent who was covered under the Previous Plan, the insurance will be effective on the date the Dependent becomes eligible for it.

(2) If you elect to insure a Newly Acquired Dependent other than a newborn or adopted child or child placed for adoption, within 31 days after the date you become eligible for Dependent Insurance for that Dependent, the insurance will be effective on the date of election.

(3) If you elect to insure a Newly Acquired Dependent who is a newborn or adopted child or child placed for adoption within 31 days after the child's date of birth, adoption or placement for adoption, the insurance will be effective on the child's date of birth, adoption or placement for adoption.

(4) If you elect to insure: (a) a Newly Acquired Dependent more than 31 days after the date you become eligible for Dependent Insurance for the Dependent (including a newborn or adopted child or child placed for adoption); or (b) a Dependent who was not covered under the Previous Plan, the insurance for the Dependent will become effective on the date CIGNA agrees in writing to insured that Dependent.

(5) If the insurance on a Dependent ceases because you stopped making premium payment for that Dependent and you again elect to insure that Dependent, the insurance will become effective on the date CIGNA agrees in writing to insure that Dependent.

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order. You must notify CIGNA and elect coverage for that child within 31 days of the QMCSO being issued.

Under the circumstances described in items 4 and 5 above, CIGNA may require you, at your expense, to submit evidence of the Dependent's good health before it agrees to insure that Dependent.

You will be insured for Dependent insurance only if you are insured for yourself under the policy.

Any reference to an insured Dependent means a Dependent for whom you are insured.

Termination of Insurance

Insured Persons

Your insurance will cease on the earliest date below:

(1) the date the policy is cancelled

(2) The date you cease to be eligible as described in the "Who is Eligible – For Insured Persons" section;

(3) The date you become eligible to be covered as an employee, member or dependent under a group medical care plan sponsored by an employer, union, association or similar entity;

(4) The end of the period for which you have paid the required premium.

Notice of Cancellation of Medical Insurance

CIGNA will send you written notice at least 15 days prior to the end of the grace period stating that if the premium has not been paid by the end of the grace period, the policy will be cancelled due to non-payment of premium.

Dependents

Your insurance on any one of your Dependents will cease on the earliest date below:

(1) The date your insurance ceases for any reason except for your death.

(2) The date the Dependent ceases to be eligible as described in the section entitled, "Eligibility for Insurance – For Dependents".

(3) The date the Dependent becomes eligible to be covered as an employee, member or Dependent under a group medical care plan sponsored by an employer, union, association or similar entity.

(4) The end of the period in which you have died, provided the required premium has been paid for the Dependent for that period.

(5) The end of the period for which you have paid the required premium for the Dependent.

The Dependent may be eligible to be insured as an Insured Person under the terms of the section entitled, "Eligibility for Insurance – For Insured Persons."

Termination of Insurance

Insured Persons

Your insurance will cease on the earliest date below:

(1) the date the policy is cancelled~~, except that if you were insured under this policy on the cancellation date, you are entitled to become insured for yourself and any of your then insured Dependents, without evidence of insurability, under another medical policy then being offered by CIGNA.~~

(2) The date you cease to be eligible as ~~a~~ described in the "Who is Eligible – For Insured Persons" section;

(3) The date you become eligible to be covered as an employee, member or dependent under a group medical care plan sponsored by an employer, union, association or similar entity;

(4) The end of the ~~3 month~~ period for which you have paid the required premium.

Notice of Cancellation of Medical Insurance

CIGNA will send you written notice at least 15 days prior to the end of the grace period stating that if the premium has not been paid by the end of the grace period, the policy will be cancelled due to non-payment of premium.

Dependents

Your insurance on any one of your Dependents will cease on the earliest date below:

(1) The date your insurance ceases for any reason except for your death.

(2) The date the Dependent ceases to be eligible as described in the section entitled, "Eligibility for Insurance – For Dependents".

(3) The date the Dependent becomes eligible to be covered as an employee, member or Dependent under a group medical care plan sponsored by an employer, union, association or similar entity.

(4) The end of the ~~3-month~~ period in which you have died, provided the required premium has been paid for the Dependent for that period.

(5) The end of the ~~3 month~~ period for which you have paid the required premium for the Dependent.

~~(6)The end of the 3-month period in which the Dependent ceases to qualify as a Dependent provided the required premium has been paid for the Dependent for that period. (However, in no event will a Dependent's insurance cease on a date that is earlier than the last day of the month following the month in which the Dependent no longer qualifies as a Dependent.)~~

~~With respect to items (1), (5) and (7) above, t~~The Dependent may be eligible to be insured as an Insured Person under the terms of the section entitled, "Eligibility for Insurance – For Insured Persons."

Termination of Insurance

Insured Persons

Your insurance will cease on the earliest date below:

(1) the date the policy is cancelled, except that if you were insured under this policy on the cancellation date, you are entitled to become insured for yourself and any of your then insured Dependents, without evidence of insurability, under another medical policy then being offered by CIGNA.

(2) The date you cease to be eligible as a described in the "Who is Eligible – For Insured Persons" section;

(3) The date you become eligible to be covered as an employee, member or dependent under a group medical care plan sponsored by an employer, union, association or similar entity;

(4) The end of the 3 month period for which you have paid the required premium.

Notice of Cancellation of Medical Insurance

CIGNA will send you written notice at least 15 days prior to the end of the grace period stating that if the premium has not been paid by the end of the grace period, the policy will be cancelled due to non-payment of premium.

Dependents

Your insurance on any one of your Dependents will cease on the earliest date below:

(1) The date your insurance ceases for any reason except for your death.

(2) The date the Dependent ceases to be eligible as described in the section entitled, "Eligibility for Insurance – For Dependents".

(3) The date the Dependent becomes eligible to be covered as an employee, member or Dependent under a group medical care plan sponsored by an employer, union, association or similar entity.

(4) The end of the 3-month period in which you have died, provided the required premium has been paid for the Dependent for that period.

(5) The end of the 3-month period for which you have paid the required premium for the Dependent.

(6) The end of the 3-month period in which the Dependent ceases to qualify as a Dependent provided the required premium has been paid for the Dependent for that period. (However, in no event will a Dependent's insurance cease on a date that is earlier than the last day of the month following the month in which the Dependent no longer qualifies as a Dependent.)

With respect to items (1), (5) and (7) above, the Dependent may be eligible to be insured as an Insured Person under the terms of the section entitled, "Eligibility for Insurance – For Insured Persons."

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least [15-40] hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the [New Employee Group] Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within [30 days-one year] after your insurance ceased.

[Initial Employee Group: You are in the Initial Employee Group if you are [employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer] [in the employ of an Employer on the Participation Date of the Employer].

New Employee Group: You are in the New Employee Group if [you are not in the Initial Employee Group] [your Employment with an Employer starts after the Participation Date of that Employer].]

[**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.]

Waiting Period

Initial Employee Group: [None] [[1-90] Days]

New Employee Group: [None] [[1-90 days] after date of hire] [[1-90] days from the date of Active Service] [First of the month following [1-90] days from the date of Active Service] [The first day of the month following [1-90] days from date of hire]

Classes of Eligible Employees

[Each Employee as reported to the insurance company by your Employer.]

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. [If you are a Late Entrant, your insurance will not become effective until CIGNA agrees to insure you.]

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of good health to be provided at your expense if you are a Late Entrant.

[Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CIGNA agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of your Dependent's good health at your expense if you are a Late Entrant.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.]

MEDICAL CONVERSION PRIVILEGE

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by CIGNA only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CIGNA within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- [your insurance did not cease because the policy in its entirety canceled.]

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

[**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: (a) is not eligible for Medicare; (b) would not be Overinsured, (c) has paid all required premium or contribution, (d) has not performed an act or practice that constitutes fraud in connection with the coverage, and (e) has not made an intentional misrepresentation of a material fact under the terms of the coverage.]

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CIGNA's underwriting standards for individual policies.

- Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CIGNA's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). CIGNA or the Policyholder will give you, on request, further details of the Converted Policy.

Dependent

[Dependents are:

- your lawful spouse; [or
- your Domestic Partner; and]
- any child of yours who is
  - [less than [26-99] years old.]
  - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student and primarily supported by you.
  - [26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability [which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage].

    [Proof of the child's condition and dependence must be submitted to CIGNA within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA may require proof of the continuation of such condition and dependence.]

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you. [If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.][Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.][Benefits for a Dependent child [or student]will continue until the last day of the calendar year in which the limiting age is reached.]

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.]